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ABSTRACT

This monograph on health problems and health systems throughout the world addresses the following topics: (1) global health patterns and prospects; (2) basic concepts on primary health care and prerequisites of support to primary health care; (3) organizing health system support for primary health care; (4) intersectoral support for primary health care; (5) community cooperation; (6) manpower planning and training to ensure effective functioning of health personnel; (7) allocation and use of resources and financing; (8) management and supportive supervision; and (9) health care facilities, equipment, and supplies. Concluding remarks are presented on policy considerations, action on the topics reviewed, and recommendations on the support process. (J3)

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Health Action Report for primary health care

A study based on the Technical Symposium
held during the Thirty-fourth World Health
Assembly, 1961

Bogdan M. Kleczkowski
Ray H. Elling
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Health system support for primary health care

**A study based on the Technical Discussions
held during the Thirty-fourth World Health
Assembly, 1981**

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1. Introduction

The subject of this publication is a wide one. It is concerned with human development and the urgent need to foster some understanding of the implications of health system support for primary health care and the action consequent on such an understanding. The adoption by the Member States of WHO in 1977 of "Health for all by the year 2000" as their main goal, and the recognition, at Alma-Ata in 1978, of primary health care as the key to reaching this goal marked a change of approach to health problems and health systems throughout the world.

In this section, we shall first review some of the events leading to this change and briefly consider the health situation and health prospects in the world today. Next, the need for practical action and exchanges of experience in developing health system support for primary health care will be discussed. We shall then turn to the Technical Discussions held during the Thirty-fourth World Health Assembly in May 1981, on which this publication is mainly based, and to the scope and nature of the publication itself. While it is intended as a summary of current knowledge and experience concerning health system support for primary health care, it has been written in the full realization that our understanding of this subject needs to be carried much further in many ways before the goal of health for all comes close to being realized.

Historical Landmarks: Changing Health Concepts

When Virchow wrote, in 1849, that "Medicine is a social science and politics is medicine on a large scale" (38), he clearly anticipated the broad outlook on health that exists today. But, with the work of Pasteur, Koch, and others and the establishment of the germ theory of disease in the latter half of the 19th century, much of this breadth of vision was lost in the vigorous pursuit of new medical knowledge and of the technological means of attacking specific diseases. Perhaps the crowning success of this line of attack was the recent eradication of smallpox from the human population.

Meanwhile the hospitals and the laboratories associated with them came to serve as the centres of clinical work and scientific progress. Eventually, they also came to be conceived of as the very core of the

health system, including some aspects of public health. However, in some national systems they were also used for investment and profit-making, regardless of whether the techniques applied were demonstrably necessary or effective. On the world scene, the same profit-oriented motives could be glimpsed behind the promotion of drugs and techniques in ways that were not always socially beneficial.

High-technology medicine seemed to be getting quite out of hand and leading health systems in the wrong direction—i.e., away from health promotion for the many towards expensive treatment for the few. Not only was there increasing concern about the cost and allocation of health resources, but the efficacy of modern medicine was fundamentally questioned from various points of view. Historical epidemiological studies showed that significant improvements in longevity had been achieved through improved food supplies and sanitation long before the advent of modern drugs and high technology (28). Other studies focused on the adverse effects of technological approaches in terms not only of side-effects, but of the undermining of the capacity of the individual and the family to maintain health.

Modern medicine was also attacked for its elitist orientation and its lack of accessibility to the poorer social classes, even in health systems explicitly adapted to overcome such disparities. There is now strong evidence that most forms of disease are more prevalent among people living in poverty. This evidence of the close links between health and social and economic conditions clearly brings us back to Virchow's statement that "politics is medicine on a large scale".

Global Health Patterns and Prospects

How hopeful can we be that poverty will be erased in the world, thus permitting health for all? Using the most optimistic set of assumptions, a recent World Bank report sees 630 million people still living in absolute poverty in the year 2000. On the basis of a less optimistic set of assumptions, it states that those in absolute poverty "could number 850 million by then, 100 million more than now" (42, p. 97).

However pessimistic or optimistic one is inclined to be, it is clear that the problems of human survival and development are mammoth. What can be done? At Alma-Ata, the world chose to attack the problem through primary health care. Since 1978, WHO and its Member States have worked on the development of appropriate national and regional strategies, and a Global Strategy was adopted at the Thirty-fourth World Health Assembly (51). What is needed now is more vigorous progress in the practical implementation of these strategies. Here, countries and local communities must learn through doing, as there can be no universal blueprint. But their experience must be shared so that there may be a better understanding of the concepts involved and a consequent improvement in their practical application.

This is not a call for something entirely new—rather it is a change of emphasis. There has already been much practical experience of primary

health care, both in countries that are reorienting their health systems as part of a more general transformation of their socioeconomic systems, and in innovative projects in more limited populations (7, 35). Useful lessons are also to be learned from the more distant past. Exchanges of experience, both old and new, must cover the negative as well as the positive aspects. Indeed, if improved understanding is to be achieved, they must include information, derived from careful monitoring and evaluation, of the effects of the application of the new strategies on health and human development.

Practical research is also called for. Health systems research—which explores a range of alternatives relevant to a given situation, contributes to the strategy and design of appropriate interventions, and then frankly assesses the results—can be of great help to health system managers at all levels and to health workers and individuals, including members of the community as well as “experts”. At the very least, each country and each project should maintain an adequate record of its plans, conditions, activities and results, for analysis and evaluation. In short, there is a growing need for exchanges of experience, both within and between countries, in order to facilitate progress towards the common goal of health for all.

The Technical Discussions, 1981

To stimulate the kind of exchange just referred to, “Health system support for primary health care” was selected as the subject of the Technical Discussions held on the occasion of the Thirty-fourth World Health Assembly, in May 1981. Preparatory work included consultations with a group of experts who recommended that the discussions should concentrate on the seven topics dealt with in sections 3–9 of this publication. An outline document was then sent to Member States, nongovernmental organizations, and intergovernmental organizations to stimulate discussion and obtain replies to questions on each of the seven topics. On the basis of the replies, as well as other relevant WHO reports and some country case studies, a background document was prepared for use by the participants in the Technical Discussions.

Over 340 delegates from 129 countries and organizations took part in the discussions. They were divided into six working groups, each of which discussed the common topic “Organizing support” and one of the six other topics.

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Because of the informal and unofficial nature of participation in the Technical Discussions, references to specific participants and countries are not included here, though their contributions have, of course, been extensively consulted. Other relevant material, both published and unpublished, has been used, and the authors have also drawn on their

own experience of work with health systems in various developed and developing countries over a number of years.

Because of the complexity and breadth of the selected subject, the Technical Discussions concentrated on one particular aspect, namely support from district or first referral level to primary health care action at the periphery. The present book reflects this emphasis, but it also deals with other, broader issues, notably the basic economic and social preconditions for primary health care.

Although this publication is based on the work of a forum involving a wide range of experienced people from many countries and also on a wealth of documentation, it is ultimately the authors' personal synthesis of the ideas and experiences reviewed at the Technical Discussions. While a special effort has been made to represent these ideas and experiences correctly, the authors themselves accept full responsibility for the facts and interpretations presented here.

It is hoped that this publication accurately reflects current experience in the development of health system support for primary health care; its main purpose, however, is to stimulate further practical developments and exchanges of experience. Here and there, we have drawn attention to questions needing further investigation and discussion. If the book seems provocative in parts, this is deliberate, the intention being to stimulate ideas and action.

2. Basic concepts

In this section we shall first consider primary health care itself and the main characteristics of health systems that are based on it. Secondly, we shall look at some prerequisites for primary health care as regards the economic and sociopolitical systems of particular countries, recognizing that they are, to a certain degree, dependent on a wider world system. Finally, the nature and range of the types of support necessary to primary health care will be discussed. Since some of these subjects will be considered at length (with examples from replies by countries and other sources) in subsequent sections, here we shall only briefly discuss certain kinds of support—e.g., public understanding and commitment, health policy and legislation—that are not specially dealt with in later sections.

Health Systems Based on Primary Health Care

The *health system* can be broadly defined as the coherent whole of many interrelated component parts, both sectoral and intersectoral, as well as the community itself, which produce a combined effect on the health of a population. The ideal may be to have one unified health system encompassing promotive, preventive, curative, and rehabilitative measures. Whether unified or not, a health system should consist of coordinated parts and extend to the home, the workplace, the school, and the community.

The health system is usually organized in levels. Primary health care pays particular attention to the point of initial contact between members of the community and the health services. Properly conceived, the notion of levels implies a regionalized system within which the highest priority is given to primary health care at the local level. Prevention, health promotion, and the care of common problems should constitute the main line of action. Expensive and specialized needs should be referred to secondary (intermediate) and tertiary (regional or national) levels. It is at the local level that health care will be the most effective within the context of the area's needs and limitations, duly recognizing the users of health systems as social beings in a particular environment.

Existing systems of this kind may need revision, for example, to give

greater emphasis to intersectoral measures in support of primary health care rather than health service action alone (even if this is broadly conceived in terms of health promotion and disease prevention as well as treatment and rehabilitation).

A health system based on primary health care should be particularly concerned with ensuring that such care is readily available to all, with appropriate support at the intermediate and national levels, as well as more specialized referral services when needed. Thus a well-balanced system will provide specialized skills as extensions, when needed, of the essential health services available to all in need. Rather than wait passively for problems to appear in the emergency or ambulatory services (the "come-and-get-it" approach), the health system should actively reach out to the whole population to promote health and prevent illness as well as treat problems when they do appear.

Now, what is primary health care and what are its implications as regards health systems?

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. *It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.*¹ It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (46, pp. 3-4).

According to this concept, primary health care "is also an integral part of the overall social and economic development of the community". It thus gives a whole new character and direction to the health system, in contrast to the more limited approach based on a system of health services alone. But it also includes a set of definite services and activities that must be provided to individuals and communities at the local level: As a minimum, it includes eight essential elements:

"Education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs" (46, p. 4).

It is clear from this that primary health care implies much more than concern for the clinical treatment of the ill, though adequate treatment, referral, and follow-up on the return of patients to their homes and places of work cannot be ignored. Certain widely circulated myths about primary health care should be dispelled at the outset. First, it is *not* a

¹ Authors' italics.

new health service programme to be assigned, as malaria control once was, to a separate body; it is of central concern to all the components of the health system. Secondly, it is *not* second-class care relevant only to rural areas or to poor people in cities. At its best, it represents the essence of first-rate care in both urban and rural settings. Finally, it is *not* a way of placing the whole burden of health care on the shoulders of individuals and of local communities. It involves, rather, the inclusion in the health system of individuals and communities as responsible partners with health workers and health institutions in the pursuit of common health goals.

In short, a well-balanced health system based on primary health care should:

- encompass the entire population on a basis of equity and responsible participation;

- include components from the health sector and from other sectors whose interrelated actions contribute to health;

- provide the essential elements of primary health care at the first point of contact between individuals and the health system;

- support the provision of primary health care at the local level as an important priority;

- provide, at intermediate levels, the skilled and specialized care needed to deal with the more technical health problems requiring referral from the local level, as well as continued training and guidance for communities and community health workers;

- provide, at the central level, planning and managerial skills, highly specialized care, teaching for specialized staff, the services of such institutions as central laboratories, and central logistic and financial support;

- provide coordination throughout the system, with referral of problems between levels and among components whenever appropriate.

Prerequisites of Support to Primary Health Care

Before discussing the question of support, certain factors that may encourage or discourage the primary health care approach should be identified. By examining the role of each of these factors in their own countries, readers will be better able to judge the relevance to their own situations of experience elsewhere.

Commitment to social and economic justice

To be realized, primary health care and health for all require commitment to social and economic justice:

"The overall social goal of health for all has to be broken down into more concrete social policies aimed at improvement of the quality of life and maximum health benefits to all. If the gap between 'haves' and 'have-nots' is to be reduced within and among countries, there will be a need in most countries to formulate and put into effect concrete measures for

more equitable distribution of resources. In many countries this will imply the preferential allocation of health resources to those in greatest need as an absolute priority, as a step towards attaining total population coverage" (47, p. 12).

On the basis of estimates of their economic and sociopolitical characteristics, the health systems of every country may be situated within a matrix. The economic dimension of this matrix may be rather easily scaled in terms of per capita GNP (although this measurement ignores the distribution of incomes within a country). The sociopolitical characteristics of a country, or of its health system, require more qualitative analysis; this can be based, for instance, on the system's embodiment of certain values which may be examined under such headings as "health as a societal value", "collectivism versus individualism", and "distributional responsibility" (24).

Health systems may also be graded according to their administrative structure—that is, from governmental to private, from centralized to decentralized, and from pluralistic to unified. Thus, a sociopolitical framework that vests great power in government and leaves little room for private enterprise would be expected similarly to vest all or nearly all health responsibilities in government and have little private medical practice; while, at the other end of the scale, private medical and hospital services would be strong and governmental health programmes weak. Centralization in the general sociopolitical framework would yield centralized controls, standards, and management in the health system; decentralized policies would generate similarly decentralized financing and control of hospitals, health insurance, and other health programmes. A pluralistic ideology would undoubtedly be associated with a multiplicity of health programmes and numerous challenges to the achievement of coordination, whereas a generally unified political structure would almost certainly lead to the merging of all or nearly all health responsibilities in a single agency—typically a ministry of health. All these sociopolitical aspects of health systems may be condensed into a scale of organization ranging from modestly, through moderately, to highly organized.

A conceptual matrix of the characteristics of national health systems, based on these two factors—the national economic level and the health system's degree of organization—is presented in Table 1. Theoretically, every national health system in the world could be placed in one of these nine categories. In some categories there would be many health systems, and in others only a few. Moreover, the economic and sociopolitical characteristics of countries and their health systems are continually changing, so that a system might be in one category now and in another five years hence.

Subject to this possibility, Table 1 may offer general guidance for the development of strategies to reshape national health systems. The amplitude of health resources is bound to be much greater in categories 1, 2, and 3, for example, than in categories 7, 8, and 9, and reorientation strategies should obviously take this into account. Similarly, the role of

Table 1. National health systems: typology based on national economic levels and degree of health system organization*

National economic level	Degree of health system organization		
	Modestly organized	Moderately organized	Highly organized
Developed (affluent)	1	2	3
Developing (transitional)	4	5	6
Least developed (poor)	7	8	9

* Source: KLECZKOWSKI, B. M. ET AL. (23).

the private sector in financing health services is much greater in categories 1, 4 and 7 than in categories 3, 6, and 9, and this must obviously influence the planning of any system changes. It is likely that most of the world's national health systems do not belong in the extreme categories (1, 3, 7, and 9) but rather in the intermediate zone (2, 4, 5, 6, and 8). In any case, health strategies must be highly sensitive to the precise characteristics and circumstances of each country's health system.

Value judgements, based on the category into which a national health system falls, must, of course, be avoided. Within each group, certain systems may rank higher than others on criteria of "relevance", "coverage", "effectiveness", and "efficiency" (54). National health systems that are rather loosely structured (modestly organized) but highly efficient may have the optimum effect on the health of their populations. On the other hand, some highly organized but resource- or structure-oriented systems could have a less than optimum effect on health, because of organizational rigidity or inadequate financial support.

Equitable provision of health care

The main criterion for moving towards primary health care in all cases is the increase in social and economic justice in the use of health resources which is at the heart of this approach. Although certain organizational forms may place greater weight on this aspect, it is the equitable provision of health care to all people that will be the measure of success.

There is some suggestion, however, that certain organizational features are more efficacious in this regard. In general, if local structures for coordination and concerted action are well developed, a decentralized system can encourage the cooperation and local initiative in a regionalized context that will give the best chance of fully realizing the primary health care approach.

Political will

The translation of values into action, however, requires two further elements: political will and economic resources. Much has been written about "political will", as if it could occur in any political/economic context, bringing policy, budget, and other support to primary health care in its wake. In reality, however, political commitment is much more complex. Official declarations are a useful step but are not always followed by meaningful action. Sincere official commitments may be delayed or blocked by disagreements among various interested groups over the ways in which such commitments are translated into action. Furthermore, it must be recognized that political will is a result of collective social concern and, as regards support for primary health care, that the only useful form of political will is the willingness to take effective action.

Economic resources

It is well known that levels of economic resources are closely correlated with such general indicators of health status as infant mortality and longevity. The adverse effects of poverty on health within population subgroups are also well known. But evidence is accumulating that improvements in the allocation and distribution of resources within a system of social and economic justice can be more important for health than the level of resources *per se*.

The development of health systems based on primary health care will require increased resources, as well as the reallocation of existing resources. Funds must be generated from new as well as traditional sources to match resources with primary health care responsibilities at the periphery of the system (48, 57). National decisions aimed at the adequate financing of primary health care will require widespread commitment and clear policies. This matter is further discussed in chapter 7, which deals with financing.

Types of Support

Every human endeavour depends on the environment in which it takes place for the means with which to pursue the desired goals. Whatever the social unit concerned—whether the local health centre, the district hospital, the regional health system, the ministry of health, or the country as a whole—the flow of support to it will depend on both internal and external factors.

Not every kind of support can be covered here. Tentatively, the support needed from the health system for primary health care may be classified under three headings:

- (1) *Promotion of primary health care*
—establishment of policy and priorities

- mobilization of intersectoral support
 - legislation
 - mobilization of community support.
- (2) *Development of primary health care*
- planning and programming, including intersectoral coordination, choice of appropriate technology, community participation, evaluation, and appropriate research
 - manpower development, including reorientation of existing workers and training of new ones
 - organization, including referral mechanisms
 - provision of financing and facilities.
- (3) *Functioning of primary health care*
- management of resources, including finance, manpower, and information
 - coordination of components, including both sectoral institutions and communities
 - supportive supervision
 - provision of equipment, supplies, and drugs.

Thus, support to primary health care must encompass its promotion, development, and functioning. These form a continuous cycle, and commitment to all of them is needed on a permanent basis if a health system based on primary health care is to grow and develop as it should. For this to happen there must be widespread understanding and acceptance of the importance of primary health care by the general public, as well as by politicians and decision-makers.

Commitment to primary health care may face serious obstacles on account of imperfect understanding of its implications. For example, in a developing country, leaders may believe that a valuable gift is being given to the nation in the form of an elaborate hospital, offered by well-meaning but misguided officials and citizens of an industrialized nation. Several multinational suppliers of sophisticated medical technology may happily cooperate in this "aid" project. But, once built, the hospital, serving only a small proportion of the population, will take a major part of the health budget, leaving few national resources for primary health care for the majority of the population. Where such resources are committed without regard to achieving an appropriate balance between the need for primary care facilities and the need for support and referral facilities, a health system based on primary health care cannot be developed. Elsewhere, the earlier "basic health services" approach is being doggedly followed and peripheral health units have started to call themselves "primary health care centres" without altering their passive, curative role, and without assuming any real responsibility for the health of the entire community in which they operate or for intersectoral issues. Other countries have assembled a large number of proposed projects for medical care facilities and manpower for which they are seeking international transfers of funds and other support. While, after Alma-Ata, the names of the projects may have been changed to include the words "primary health care", the projects themselves only perpetuate

the old inequities or inequalities that primary health care seeks to overcome.

Establishment of policies and priorities

To become effective, commitment to primary health care must be translated into clear statements of government intent, supported by appropriate legislation. Priorities for action must then be chosen on the basis of these policy statements. The local community should play a major role in identifying problems and setting priorities. For example, experience in some countries suggests that, for the health services to play a proper role in wider development efforts, they must first ensure the provision of care for acute cases and support for referral at the periphery, since this is what most people mainly expect of the health services. Once this is provided, a more vigorous role can be played in assisting communities to organize improved food and water supplies, sanitation, health education, etc.

Legislation

Legislative action is usually required to ratify national policy, to ensure financing, and to monitor and regulate action. Specific legislation may also be needed, such as the authorization of institutions for training primary health care manpower or laws allowing health auxiliaries to administer selected essential drugs and give immunizations.

* * *

The types of general support described above are critical in organizing a health system based on primary health care. In the following chapters specific types of support are described.

3. Organizing health system support for primary health care

The most serious inadequacies of present systems of health care arise from the interrelated issues of accessibility, selection of techniques, and cost. *Accessibility* has both geographical and social components. In developing countries, extension of the geographical coverage of even minimal health care has been agonizingly slow. In developed countries, increasingly complex new technology has often resulted in a concentration of health care both geographically and socially, resulting in greater reliance on specialized knowledge and a decrease in the capacity for self-care. This has made health services less accessible for many people, particularly those outside urban areas.

The *selection of techniques* for use within the health system has commonly been based on the indiscriminate application of new methods in an attempt to keep up to date, irrespective of effectiveness and cost. This has been most disastrous for the poorer developing countries, in which the price of keeping a few urban hospitals up to date by the technological standards of developed countries has been an inability to provide the majority of their citizens living in outlying areas with even the most essential health services.

The rising *cost* of health services has aroused increasing concern in both developed and developing countries. It is associated with a variety of factors, including the use of expensive techniques as well as staffing and other problems related to the organization and financing of health services. Particularly in some of the developed countries, the increase in cost appears to be considerably greater than any corresponding improvement in health or welfare.

A reasoned analysis of these and other factors indicates the need for a fundamental reorientation and reorganization of existing health systems if the social goal of health for all is to be achieved. Changes will be needed at all levels: individual and community, intermediate and national. Some prerequisites at the national level were considered in section 2. The present section will broadly consider various aspects of the organization of support for primary health care.

The first aspect is mobilization of the necessary *public and professional support*. This includes popular support, the support of leaders and decision-makers at each level, and the support of health

personnel. While some of these factors will be considered in more detail in subsequent sections (especially sections 5 and 6), they are discussed briefly here because of their importance in the initiation of structural changes in the health system.

The second aspect is the study of *patterns of structural organization* in the health system. Here, particular emphasis is placed on the definition of activities to be undertaken and the selection of techniques to be used at the community and intermediate (or district) levels.

The allocation of responsibilities among various institutional components of the health system is considered next. *Decentralization*—the extent of managerial responsibility assigned to each administrative level—is a major concern here. Another major concern is the allocation of responsibilities for various programme activities among institutions and personnel at each level. This is widely discussed under the heading *integration*, which, as we shall see, has many different meanings.

Finally, two vital *managerial aspects* will be considered. These are the organizational linkages for referral and information exchange. (Other managerial support activities will be considered in sections 8 and 9.)

Mobilization of Public and Professional Support

The support of individuals and communities is critical for primary health care. Although community participation will be more fully discussed in section 5, several ways of fostering it will be considered here.

In a number of countries, the implementation of primary health care began with substantial efforts to muster popular support. These included varying mixtures of simple provision of information, education through discussion, and decision-making about appropriate approaches to the implementation of primary health care in specific national, regional, and local settings.

Several means have been used with some success. Schools and other educational institutions, as well as existing health education programmes, have taken part in information-sharing and educational efforts. Mass media, particularly radio and television, have been used, although in many countries these may not reach large segments of the rural population.

Irrespective of the level of literacy or the availability of mass media, mobilization through existing organizations, both traditional and modern, can be quite successful. Among the organizations that have been used or suggested for mobilizing support for primary health care are political parties, organizations for women and young people, trade unions and other workers' groups, religious or ethnic bodies, and government agencies. The major prerequisites for effectiveness appear to be a strong "grassroots" base and an organizational structure capable of stimulating thought and action at the community level, combined with the willingness of organization leaders to become involved in primary health care efforts.

Such efforts often require specific inputs of resources to stimulate and catalyse action in local communities. These are needed not only to meet the costs of communication, meetings, and training activities, but also for such activities as the organization of transport for local participation in immunization or family health or the setting-up of village stores of drugs. Inputs of this kind can be very useful in promoting popular interest and support, provided they are related to obvious local interests and concerns and the public is adequately informed.

The importance of dialogue between communities and primary health care workers is frequently emphasized. Efforts at public mobilization must be based on *sharing* knowledge and experience. Primary health care begins with community and individual priorities and local environmental and social situations. It is not a blueprint or plan to be applied in a standardized way, but a dynamic and flexible approach to be adapted to each set of local needs and circumstances. An analysis of successful efforts at community development, including health promotion, confirms the critical importance of the sharing of perceptions and insights between citizens and professionals on an equal basis so that plans and activities may be tailored to local needs.

The flexible approach suggested above requires major changes in the ways in which government and project personnel work to develop social support. It requires decentralization of planning, decision-making, and financial responsibility. It also implies a reduction in central control over choices made and over the use of resources. These organizational aspects will be considered in more detail later.

Even a solid base of popular support may be ineffective, however, unless there is adequate support from social and political leaders and decision-makers. The mobilization of leaders at community and intermediate levels has been a key early step in the development of support for primary health care in many countries. Where there are effective political organizations, these can be used very successfully for stimulating widespread discussion, involvement, and support for further action. In a number of countries, the mobilization of local leaders for primary health care has probably been as important as, or even more important than, the mobilization of health personnel.

The existence of a committed nucleus of support for primary health care at a high political level can greatly facilitate the mobilization of more general support. An increasing number of countries are developing high-level coordinating bodies for national health systems based on primary health care—e.g., national health councils.¹ Such groups with high-level, broadly representative, intersectoral membership can do much to mobilize support at all levels and particularly among government leaders. Although the mobilization of leaders in the private sector and in

¹ See: *National health development networks: report on an interregional consultation* (unpublished WHO document SHS/83.2).

nongovernmental organizations is said to be useful, experience in this regard has so far been scanty.

The implementation of the primary health care approach, despite its emphasis on community involvement and intersectoral action, also demands the reorientation and strong support of health workers of all types. Thus the motivation of health personnel is of critical importance, particularly since primary health care will often require them to assume new roles and responsibilities.

If a general climate of commitment towards primary health care prevails in a country, the motivation of health personnel may naturally follow since there are likely to be specific incentives and appreciation for good work. Where a general commitment to primary health care is lacking or only partially evident, efforts to reorient the motivational structure are especially important. In either case training, conditions of work, and incentives must be appropriate to the effort expected.

Other aspects of training, particularly of health professionals, will be considered in a later chapter. The important motivational effects of various training experiences are, however, worth noting here. The social and professional values transmitted during training have a considerable effect on the attitudes of health personnel. Since much of this transmission is not explicit, attempts at reorienting training towards primary health care must make a special effort to ensure that the values and "role models" that are encouraged are supportive of such care, and appropriate changes should be made in curricula and learning methods. Opportunities for regular inservice training as well as for fellowships and further training in subjects related to primary health care are effective in providing motivation.

Working conditions can offer strong incentives—or disincentives—to involvement in primary health care. Regular encouragement, as well as supervisory and referral support, are important factors. Team-work and participation in planning and decision-making can also be motivating factors. The availability of essential supplies and equipment for work is another obvious factor—but one that is all too often lacking, particularly in the case of community and health centre workers.

Salary and other material incentives are also important. For example, one country increased salaries for physicians in rural areas by 50% while keeping salaries in urban areas relatively constant. Nonmaterial incentives are often overlooked, though they can be very effective.¹ Opportunities for career advancement have a motivational value beyond that of the associated material benefits. Enhanced status, respect, and social and peer recognition for useful contributions to primary health care can be very powerful motivating factors and cost very little. Particularly among professionals, the intellectual challenge of providing effective primary health care to all the population of an area is a remarkably exciting one. This excitement needs to be transmitted to

¹ See: ISRAEL, E. *Incentives offered to civil servants in the medical field for services in remote, semi-rural and rural areas* (unpublished WHO document SHS/76.1).

health workers at all levels, both in educational programmes and through enthusiastic leadership within the health system. The promotion of health in the context of socioeconomic development can be as intellectually stimulating as laboratory research; in fact, there is a great need for action-oriented research as an integral part of the development and management of health systems based on primary health care.

Special attention has been paid to the need for motivating professional health workers, particularly doctors and nurses, to support primary health care. Some observers have suggested that the attitude of doctors to such care is so negative that they are best left out. Others think that it may be worth while to mobilize their support. In many countries, professional groups are a major political force that must be considered in the promotion of primary health care. They are also a potential force in the support (including referral care) as well as the training and supervision of peripheral health workers. There are some irreconcilable conflicts, as regards health priorities, between the individualized, curative approach of existing medical care systems and the community-based, preventive outlook of primary health care. These may be accentuated by the economic self-interest of professional groups in countries with strong private medical care sectors. Nevertheless, the mobilization of professional support for primary health care continues to be an important activity, though lack of such support cannot be allowed to hold up other efforts.

Structural Organization of the Health System

It is especially important and challenging to exchange and utilize the experience of different countries in organizing the health system so that primary health care services are fully backed up by personnel and facilities at the first referral (intermediate or district) level. While support must be given to the promotion, development, and application of the primary health care approach at all levels of the health system, the intermediate level usually provides the main *direct* support. It is the link between local health activities and the successive levels of referral and specialized services provided by the remainder of the health system. Thus primary health care activities in the community are supported by successive levels of referral facilities. These engage more highly trained staff who are capable of dealing with a progressively wider range of specialized health interventions requiring more sophisticated technology than can be provided at the community level.

What do replies from countries reveal about the present state of direct support for local primary health care activities?

—Some say they have established such activities at the periphery by training village-level health personnel who function with little or no support from the established health services. These countries have only the most limited support structures at the intermediate level. Local health personnel and communities can become discouraged unless they have technical back-up and supervision, an assured supply of drugs and

other resources, a network that encourages prompt attention to referred patients and continuity of care upon return, and inservice training on a regular basis.

—Some replies outline a clear formal structure, but say that its performance is poor when it comes to supervision, supply, or continuity of care following referral. This is often because intermediate-level institutions, even when present, lack the resources—material or human—to provide adequate support. Greater decentralization of both resources and responsibilities may be needed if support activities are to be carried out as intended.

—Even in countries where primary health care tends to be narrowly defined in terms of personal health services (mostly the industrialized countries), support for local health services is often a problem since hospital budgets consume as much as 90% of the health care budget. Hospitals represent both a force competing with primary care services for scarce resources and an enormous potential source of support for primary health care. But major reorientation is required to realize this potential for support. A review of present and possible activities, accompanied by decisive action, will be needed to reorient the enormous human and technical resources of hospitals towards the support of primary health care in defined geographical areas and population groups.

Administrative levels

The individual or family

The primary health care approach has broadened the concept of the health system to include not only health facilities but also communities and families as important agents of health. The most basic health unit is therefore that of the individual or family. Increasing emphasis is being placed on personal responsibility for health promotion. The attention paid to the encouragement of healthier life styles, particularly in industrialized and urbanized areas, and the promotion, in some countries, of home-made oral rehydration solutions with which mothers can treat childhood diarrhoea themselves, are both manifestations of this emphasis. Indeed there is now a flood of information, varying widely in reliability, aimed at strengthening the capacity of individuals for self-care (25).

The community

The next level of health action is the community. The role of the community in primary health care will be dealt with at greater length in section 5, but a few observations on patterns of community organization for health may be made here. The first is that effective primary health care action at this level demands a strongly organized community. Whether derived from traditional patterns or from local political or other groups, some clear structure appears to be essential.

Where a community is very loosely knit without any clear structure, such a structure may need to be developed before further steps can be taken.

It should also be noted that the term "community" need not always be defined geographically but can stand for a group of people with some common interest. Particularly in urban and periurban areas, where the sense of geographical community may be weak, social, ethnic, or religious communities may provide appropriate starting-points for primary health care.

There is much variety in the ways communities have organized themselves to fulfil health objectives. In rural areas in developing countries, however, the most common pattern has been either a village development committee or a village health committee. Experience so far suggests that the broader development committee is more relevant to local needs and is preferable to an independent health group. In larger communities, a health subcommittee under the development committee may be appropriate.

One of the most critical tasks of such community groups is the identification and pursuit of local primary health care goals and activities. At the same time, health workers from higher levels have an important role to play in fostering awareness of the needs of special groups and of interventions possible at the community and individual levels. This should be done in a spirit of cooperation, with respect for local priorities and decisions.

Wherever possible, local plans and priorities should be based on information about the actual health needs and problems of all members of the community. Groups at high risk can thus be identified, along with special needs, and priorities can be established and progress monitored on the basis of this information. Although rather ambitious, such an approach is feasible and has been carried out in several developing countries. In one relatively poor village, a group of four part-time health workers carried out health examinations of each member of the population of 1500. Before this work began, community discussions were held to explain the purpose of the examinations and to overcome the resistance of the older women to being examined by young health workers. The value of avoiding time lost from work because of illness became clear in discussions, and the resistance melted. From then on the health workers kept a card for each person indicating the tasks to be performed, the person responsible for the tasks, and the progress made. At the end of each year, the community health workers submitted reports of their successes and failures. These reports were then used as a basis for local corrective action and for improved support from higher levels geared to actual experience.

The community health worker

The community health worker introduced in the above example can be considered as the next level of the health system after the community

itself. The term is used to refer to workers whose special characteristic is that they are administratively responsible to the community rather than the health service and should be selected by the community from among its own members. Considerable experience in the training and use of community health workers has accumulated in recent years (34).¹ There have been wide variations in the length of training, the range of activities undertaken, the size of the population served, the amount of time devoted to health activities, and the machinery for monitoring and support. While there is very little information about the impact of these workers, experience suggests that they have aroused widespread interest and that they have used a variety of approaches with some success.

One organizational matter on which there is increasing agreement concerns financial support for community health workers. Initially there was much outside enthusiasm for schemes whereby communities would spontaneously provide support in cash or kind for community health workers, or whereby these workers would serve as unpaid volunteers. While this approach has been sustained successfully in a few countries, in most places it has led to a rapid decline in the activities of community health workers after initial training, and a high drop-out rate after a year or two. It thus appears that more secure financial support from the communities concerned or from the outside (possibly channelled through the communities) will need to be ensured if community health workers are to carry out a wide range of activities over a period of several years.

Despite this problem, the hundreds of thousands of community health workers trained in recent years have done much to improve health knowledge and action in their areas. Furthermore, they are an important link between the community and the organized health service structure. They are playing an increasing role in community education and the provision of health services, as well as in the collection of health information by a variety of methods, including the use of the lay reporting of health data (45).

The basic health service unit

The next level may, by way of simplification, be called the basic health service unit—a term that covers health centres and their satellite clinics and outreach units, dispensaries, ambulatory clinics, and similar facilities staffed by full-time health workers. These facilities and their local variations are well known and need no further description. It should be noted, however, that each of the various types of institution at this level may have different sets of functions and responsibilities. Furthermore, as they constitute the part of the general health services that is in most direct contact with the community, these units are very

¹ See also: UNICEF/WHO. *The community health worker: report on an international study and workshop* (unpublished WHO document PHC/80.2); and *Community health workers: report on an interregional study and workshop* (unpublished WHO document SHS/HMD/84.1).

important for primary health care. However, because many of them have traditionally been concerned mainly with providing treatment services, they may need considerable reorganization as regards tasks, training, and reorientation, if they are to meet the challenge of helping and supporting communities and community health workers to achieve their local health goals.

The intermediate or first referral level

Beyond the basic health service units is the *intermediate* or *first referral* level, which usually has a clearly defined local responsibility for the planning, management, and coordination of all health activities within its particular area. As noted earlier, this level is the main focus of concern, since it is usually the most peripheral level capable of providing wide-ranging technical and administrative support for primary health care.

Initial attempts have been made to identify the activities, techniques, and support appropriate to each level in respect of some of the essential elements of primary health care. While there can be no universal criterion, it is helpful to consider the range of potentially useful options. The selection of activities must be based on the priority problems in each area; these may be expected to vary with time, and the selection should be reviewed regularly. A campaign to teach mothers how to carry out oral rehydration may be followed, for example, by an improvement in the water supply, with the result that the effort needed to maintain the correct use of oral rehydration will be reduced.

The selection of priorities depends, of course, on the techniques available. Where there are several choices of technique, the selection should be based on considerations of effectiveness, complexity, cost, and social acceptability. Often the choice of technique will differ from level to level. For example, a community health worker may be trained to suspect tuberculosis and refer anyone with a chronic cough to the health centre. The health centre may be able to carry out sputum microscopy for diagnosis. A patient failing to respond to adequate treatment might be referred to a regional hospital where culture and drug sensitivity tests can be undertaken. The realistic and appropriate allocation of tasks and techniques among the various levels according to local needs and available resources can eliminate unnecessary duplication and contribute to a more effective use of resources.

Decentralization: Distribution of Managerial Responsibility

Several structural aspects of the health system have an important bearing on support for primary health care. The first is the relationship between the various administrative levels and the role and extent of managerial responsibility allocated to each. The tendency towards "regionalization" was mentioned in the previous section; this should be

examined more closely from the standpoint of ensuring adequate support for primary health care.

The experience of most developing countries has been remarkably consistent in that until very recently no components of the primary health care "management unit"—from the community to the district health office—have had either the opportunity or the resources to be significant partners in planning, resource allocation, or even effective operational management in many cases. Health planning has been carried out at the national level. Both financial and manpower resources are usually allocated nationally, with little or no possibility of reallocating either type of resource at the intermediate level and below. Furthermore, on a per capita basis the proportion of the health resources allocated to primary health care management units in rural areas is usually a small fraction of that provided for urban areas.

The primary health care approach with its call for community involvement has stimulated a re-examination of the distribution of responsibility in the health system. The effort to mobilize community resources has been accompanied by significant community control over their use. It has been much less common for control of *government* resources to be shifted towards the periphery, although a number of countries have reported major shifts of responsibility for both planning and resource allocation to the regional and sometimes the district level.

In the more developed countries, a number of structural models exist, ranging from highly decentralized systems, in which nearly all planning and resource decisions are made by local health authorities, to highly centralized ones with a varying degree of local participation in planning, and taking final decisions on, resource allocation. It should be recognized that there is an inherent conflict between the desire for greater local participation in response to felt needs and the national concern to ensure a redistribution of resources in the interest of greater equity and to deal with problems that may not be apparent at the local level but are potentially important none the less. There is always a risk that, without some explicit constraints, a community may prefer to use its resources to upgrade the local hospital, say, rather than to extend the coverage of the local maternal and child health or immunization services.

If one accepts the existence of this conflict, general discussions of decentralization can be narrowed down to a consideration of ways in which an appropriate balance of responsibility among the various levels might be achieved. The direct source of financing is of some importance here: where financing is centralized, local control is usually much less strong than where revenue is generated locally.

The distribution of responsibility within the health system is almost always a reflection of the general pattern of government. Thus most of the countries which have organized a major shift of planning or financial responsibility towards the local level have done so as part of an overall decentralization programme throughout the government system.

However, even without such a shift, there are examples of the delegation of greater responsibility for health on the basis of local needs.

At the present time, however, the intermediate level in most countries has little to do with strategic planning, little or no control over the use of the available budget, and little flexibility as regards the support of any community initiatives that arise. There is a general feeling that more responsibility, and more resources, are needed at the intermediate level if it is to give adequate support. Within primary health care management units there are numerous examples of greater sharing of responsibility between the intermediate, basic health service, and community levels in planning and carrying out health activities within the limits of the locally available resources. These examples are indicative of a growing trend, but, in the majority of developing countries, management remains highly centralized despite the obvious problems this creates for the development of primary health care.

Integration: Distribution of Programme Responsibility

Another factor of particular relevance to support for primary health care is the distribution of responsibility for various health programmes, such as curative services, maternal and child health, and communicable disease control. The term "integration" is used in a variety of situations, most notably in connection with the balance between curative and preventive services and the relationship between single-purpose programmes (such as malaria or tuberculosis) and the general health services. The extent of these relationships usually varies at different levels, although this is commonly overlooked. An additional factor is the balance between the functions of supervision and technical support and responsibility for administrative control between levels and among programmes.

The question of integration has been widely debated for many years, and most discussions on the subject have generated more heat than light. If we are to judge by the patterns of responsibility for different functions reported at the Technical Discussions, the issue is still not resolved. However, there has been a steady movement towards greater coordination, and this appears to have accelerated in the past few years.

Community level

At the community level integration has seldom been an issue. Most community health workers are being trained as multipurpose workers. In a number of countries where single-purpose village workers were already available, these workers—family planning advisers, agents for the distribution of antimalarial drugs, etc.—have often been selected for training as community health workers. There are, however, some examples of specialization among community workers under coordinated administrative control that appear to be satisfactory.

Mobile workers

There continue to be a variety of specialized mobile workers in many countries who provide services on a periodic basis in communities. Teams of these workers are still being used quite effectively to provide greater access to services more sophisticated than can be provided by community health workers, notably immunization and various other forms of communicable disease control. However, because of their centralized and hierarchical structure, such efforts are often inappropriate for the support of primary health care in its broader aspects; indeed, they may sometimes be so authoritarian in approach as actually to discourage community involvement. Many countries are moving towards greater integration of these services with the general health services. This trend has accelerated with the escalation of costs and the desire to maximize the effectiveness of limited transport by combining special programme activities with supervision, supply, and other supporting functions.

Health centre level

It is perhaps at the health centre level that the question of the integration and coordination of functions becomes most acute. Countries report a wide variety of organizational patterns at this level. The separation of preventive and curative functions is commonly reinforced by established roles and training programmes that allocate treatment to one category of worker based exclusively in the health centre, while "public health" functions such as food inspection, sanitary inspection of public places, and environmental health efforts are assigned to another worker, with little interaction between the two workers and often little involvement of either with the surrounding community.

However, examples were also provided of instances in which health centre staff with a combination of general and specialized skills have worked as a team with communities and with each other to satisfy priority needs. The most successful of these efforts have attempted to organize activities around community needs rather than those of the health staff. For example, instead of holding clinics on separate days for pregnant women and for children, these are combined, so that prenatal care of a pregnant mother with young children and the immunization and nutritional surveillance of her children can be done at the same visit to the health centre. Working in teams does not imply any lack of specialized activities, but rather a more coordinated and participatory approach in organizing the priority activities of the health centre, giving appropriate emphasis to those implemented in the community as well as those carried out in the health centre itself.

In a number of countries, there are still special health projects with specialized staff working at a level comparable to that of the health centre, but completely independent of it administratively and often

physically. Such separation is particularly common in the case of antimalaria and family planning programmes. These specialized programmes often provided the only health services available at the time they were initiated. However, with the extension of general health services, countries have recognized the need for better coordination and administrative integration in order to increase efficiency and avoid duplication. These considerations have been countered by the claim that the integration of specialized programmes will reduce their effectiveness, and by other arguments relating to power and control. On the other hand, some participants in the Technical Discussions noted the use of established "vertical" projects as spearheads for the establishment of broader primary health care activities. The gradual strengthening of the priority components of primary health care in an actively promoted sequential process is a broader variation of this idea.

Level of first referral

Many of the above comments are equally applicable to the level of first referral, at which responsibility for the overall management of primary health care is exercised. Here the separation of public health and curative functions is still often institutionalized in independent units such as a district hospital or a district health office. In some countries, each of these units is under a single head—often, but not always, the hospital director. Elsewhere the two may be independently managed but responsible administratively to a Chief District Officer. More frequently official coordination occurs only at the regional or national level and it is not uncommon for each district unit to report to a separate department in the national ministry of health.

While there was widespread agreement at the Technical Discussions regarding the desirability of administrative integration at the intermediate level, only a few countries reported significant progress in that direction. A greater decentralization of overall political authority to the intermediate level appeared to facilitate such integration, though it was not a uniform prerequisite. It was clear from the discussions that changes in organizational relationships at this level were a highly political issue, closely bound up with the special concerns of a variety of interested professional and nonprofessional groups. The development of the most appropriate organizational structures for support to primary health care will therefore require both more time for the necessary review of the situation and fostering of political motivation, together with a more careful analysis of the arrangements most likely to ensure effective primary health care action on the part of the components of the health services and related communities and institutions.

Managerial Aspects

The above account would not be complete without reference to two additional aspects of the organization of support for primary health

care, related to the referral and information links between the various structural and functional units and levels.

Referral

The importance of effective mechanisms for referral linking the services at various levels was emphasized during the Technical Discussions. The scope of referral was broadened to include the health problems of communities as well as those of individuals requiring medical care. It was noted that some clarification was needed regarding the types of problem that should be managed at each level and those that should be referred, and also that health workers at many levels need to be taught the proper use of referral.

The provision of incentives for referral was also discussed. Incentives to persuade individuals to accept referral, particularly when it involved travel to a distant or strange place, included the provision of transport, special attention at the receiving institution (such as being put at the head of the queue), and accompaniment by a person from the referring institution. The provision of feedback to the referring institutions on the outcome of the problems referred was noted as a major incentive for these institutions. The use of the patients and problems referred as an opportunity for inservice training was also commended.

The development of effective referral links is still greatly limited by long distances between facilities and difficulties of transport and communication in many areas. It has also been noted that, where transport is limited, its use for the referral of patients for treatment may clash with its use for outreach or supervisory services, raising questions of priority that are not easy to resolve. A referral system is nevertheless essential if the primary health care goal of equity of access, particularly to specialized health care, according to need, is to be achieved to any extent for scattered rural populations.

Exchange of Information

A final concern is the strengthening of coordination through improved exchange of information. The value of information feedback has already been mentioned in connection with referral. It is also an important tool for the motivation of personnel and for the mobilization of support for all levels of health worker. Information exchange in support of primary health care at the local level takes many forms. The more important include direct personal contacts and comments and responses to reports and requests. The traditional one-way circuits of directives sent from "above" and reports sent from "below" must be broadened to provide a two-way flow of information, with feedback in both directions. Another way of improving communication and support that has been quite successful is the publication of a regular newsletter or magazine for primary health care workers, in which experience in

different areas can be exchanged. Other media such as radio have also been used for sharing information on primary health care activities.

* * *

To conclude, the organization of support for primary health care is a many-sided challenge. The support of individuals, communities, political and social leaders, and health workers must be mobilized to initiate new directions in health development. But these new directions may also require changes in the structure and the functional organization of the health services. In particular, primary health care demands a greater opportunity for local participation in decision-making, which will usually require more sharing of responsibility between the national and local levels of the health system. Furthermore, greater coordination will be needed to see that the available resources are used to meet priority health needs, and this is likely to require a more integrated managerial process in order to ensure the effective and efficient operation of the health services. Finally, the important role of referral mechanisms and of two-way exchanges of information among various organizational units in the support of primary health care is emphasized.

4. Intersectoral support for primary health care

Since the health situation is to a large extent determined by life conditions well beyond the usual scope of the health services, the contributions of sectors other than the health sector must be mobilized in support of primary health care. Depending on the way responsibility is distributed in a country, cooperation between the health and other sectors may be more difficult than cooperation within the health sector. However, it is worth noting that the latter is often a precondition of the former.

Intersectoral Action: Needs and Problems

Although intersectoral support for primary health care is often described as "essential" and "of first importance", there is a great deal of uncertainty about how to develop it. This uncertainty seems to stem from inadequate understanding and a lack of concrete experience. In general, not much progress has been made in this sphere, and there are only a few examples of effective intersectoral cooperation—see, for example, Schaefer (36).

A better understanding of the relationships between the health sector and other development sectors is undoubtedly needed in order to avoid a repetition of some of the tragedies of the past. For instance, the construction of dams for irrigation has led to large increases in the incidence of schistosomiasis. In many countries in various parts of the world, agricultural production augments the profits of multinational business or swells local foreign exchange reserves instead of providing adequate and affordable foods for the underfed local population. Replacing the local staple crops, single crops such as soya beans are produced over large areas in developing countries as feed for beef cattle in industrialized countries. The local staple crops become scarce, with a consequent increase in price, so that farm workers—now employed for less than subsistence wages—are forced to buy unfamiliar imported grains that may also be expensive but are not nearly as expensive as the once plentiful local produce. Dependence is thus created, rather than development. There are also too many instances of developing countries accepting polluting industries and other hazards from industrialized countries in the name of development. At times, the absence of pollution

standards is widely advertised to attract outside industry, with no regard for the human hazards involved.

Effective health leadership could help to avoid such deleterious actions in other sectors. At the same time, health promotion efforts could be encouraged: these might range from health education in schools to encouraging the sinking of wells, new forms of crop rotation, and more productive locally oriented agriculture. But effective leadership is often a problem. In fact, worries over which ministry would "come out on top" in intersectoral efforts often leads to the avoidance of real cooperation. Coordinating bodies with no real authority are sometimes used to this end. Where interministerial conflicts are known to exist, a coordinating council may be set up to provide a forum for each ministry to present its plans and projects—and then do just what it was going to do anyway. However, genuine joint efforts can be encouraged by leaders who see to it that individual organizations can obtain greater support through cooperation than they could working alone. Studies on interorganizational relations have suggested that this is a key strategy for encouraging desirable cooperation between relatively autonomous organizations (2, 58).

Constraints on intersectoral cooperation in support of primary health care may thus include:

- conflicts of interest between administrative units and individuals;
- the erroneous belief of other sectors that investments in the field of health only eat up resources;
- opposition to letting another sector assume the leadership in matters having to do with health (power conflicts);
- lack of awareness of the benefits to health to be derived from action undertaken by other sectors;
- inadequate preparation of health development agents for working together.

These constraints may exist at all levels of the health system. They may reflect weak or uncertain intersectoral leadership, or arrangements for support that detract from cooperative interorganizational relations. While there is a need for a better understanding of these factors, there is also a need for more action in this area, with reports on attempts, both successful and unsuccessful, to overcome these constraints in different circumstances.

Sometimes a general interministerial coordinating body for primary health care has been set up at the national level. But, unless such bodies have the authority to institute concerted, comprehensive intersectoral programmes in support of primary health care, their influence is likely to be quite limited. It also appears that intersectoral support of primary health care may be more effectively developed at the highest national administrative level rather than being initiated by the ministry of health. One appropriate setting for a coordinating body might be within the office of the prime minister or chief executive. In countries with well-developed central planning agencies, these may be given responsibility for strengthening intersectoral coordination, especially at the planning

stage. While various systems are being developed to facilitate the coordination of health policy and action, such as national health councils and national health development networks,¹ experience with them is still limited and it is not yet clear which are the most promising directions for further development.

Another approach is to set up a primary health care office, usually within the ministry of health. Such an office can have a beneficial effect within the health sector itself if it can draw fully on the authority and prestige of the ministry as a whole to marshal the resources of the health sector in support of primary health care. But it appears that, unless the ministry of health is unusually strong, it is not likely to succeed in developing widespread intersectoral support.

Some countries appear to question the relevance of intersectoral coordination in support of primary health care. These tend to be developed countries that take a narrow view of primary health care as something limited to personal health services at the periphery. It is becoming increasingly clear that the most basic aspects of primary health care, which are taken for granted in these countries because they are seen as assured by the infrastructure of a developed society, are not necessarily assured at all. Man has not only learned to exploit and remake the environment; he has begun seriously to challenge the adaptability of human biology and human social forms with the dumping of chemical and other wastes and pollutants. Recent estimates for one advanced society place millions of people at risk of drinking chemically polluted water, some of the pollutants being carcinogenic for humans. Thus the primary health care approach, including the assurance of pure water for drinking, is also relevant to industrialized countries (8, 39). There are also a number of life-style issues that must be dealt with jointly by the health and other sectors—i.e., the health, education, and commercial sectors as regards smoking, personal hygiene, eating habits, and nutrition; the health, transport, and law enforcement sectors as regards accidents; the health, agricultural, industrial, and labour sectors as regards the prevention of occupational hazards; and the health, housing, social service, and urban development sectors as regards the adaptation of migrants to city life.

Examples of Successful Intersectoral Action

In a more positive vein, there are numerous examples of successful intersectoral action for the solution of specific problems:

—In one developing country, district health officials worked with urban planners and housing officials to develop inexpensive but much healthier housing for periurban slum dwellers. This kind of effort is also

¹ See: *National health development networks: report on an interregional consultation* (unpublished WHO document SHS/83.2).

relevant in developed countries in which conditions of municipal hygiene and housing have deteriorated for many inner-city residents.

—To take another instance, there have been national, regional, and local efforts to ensure the production of food for local needs by local farm labour, avoiding the potentially harmful effects of production principally for world markets.

—Elsewhere, there was a national policy decision to make health understanding an essential component of literacy. Thus schoolchildren learned to read, using texts with a simple but correct health content—for example, statements to the effect that human and animal waste must be kept away from the water supply, or that an infant is protected from disease by drinking its mother's milk.

—In a small local project, a rather traditional medical clinic was established in a poor rural area and invited the community to form a board of governors. After a short time members of the community expressed their appreciation of the new medical services but said that their most serious problems were not medical: "We don't have jobs, and the land here, although rich, is undercultivated by absentee landlords. Thus there is not enough to eat, so too many of our babies die and our adults are too weak to be productive." The primary health care workers accordingly joined with the people of the community in securing tracts of land that the community itself could farm cooperatively. The community could eventually feed itself and even began supplying food to the market. Ultimately the community opened a canning factory, which provided jobs, and so a creative circular process of health in socioeconomic development was established (7, pp. 70–77; 15).

The last example brings up another very important point. Whereas intersectoral cooperation at the national, regional, and even district level may sometimes seem difficult and artificial, at village level it is always completely natural and villagers themselves will insist on it if their participation is genuine. The reason, of course, is that in everyday experience the various strands of development are interwoven. The next section will go further into the subject of community participation and development.

* * *

Several factors favouring intersectoral cooperation for support of primary health care emerged from the Technical Discussions:

- The clear formulation of development policies and strategies.
- The identification of areas for intersectoral cooperation and the determination of the specific contribution of each sector to the attainment of the goals proposed. (This should take place in the normal process of planning for health.)
- The existence of coordinating mechanisms at all levels—national, provincial, local. (Some countries found coordination easier at the central level, others at the peripheral level. Intersectoral health

commissions exist in several countries but are not always effective.)

—The recognition—common to most governments, irrespective of their political, social, and economic systems—that health and primary health care are integral parts of socioeconomic development.

—Legislation in support of intersectoral action.

—The awareness that health is an input into, as well as an outcome of, socioeconomic development.

—Full support for genuine community participation, which will tend to encourage an intersectoral approach at the local level.

—The recognition of the need to deal with health hazards caused by development activities and affecting several sectors. (The health sector should use information about the results of such health hazards to influence decisions in other sectors and decisions concerning resource allocation for the health sector.)

To sum up, experience with intersectoral support for primary health care is still limited, and there is considerable uncertainty as to how such support can be encouraged. While the health sector must certainly take a lead in promoting cooperation, effective action may require direction from outside the health ministry, by a body with executive as well as coordinating powers. Although numerous concrete examples of problems suitable for joint action were cited during the Technical Discussions, further practical efforts in this area must be encouraged.

5. Community participation

"Community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development" (46 p. 50). With its aim of increasing personal and social responsibility for health and, at the same time, contributing to development, community participation is one of the principal strengths and supports of primary health care.

What Community Participation Means

Genuine or spurious?

Before going further, it is important to be clear what genuine community participation entails. Although the concept has achieved a great deal of popularity in recent years, it has not gained in clarity (5). It has been used in various, sometimes dramatically different ways.

"Does it mean extending our existing professionally controlled, centralized and stiflingly paternalistic health services to 'penetrate' the 'target' populations of poverty? . . . Or does it mean working to change the socio-politico-economic structure that perpetuates poverty, hunger, and ill health?

Does it mean increasing the dependency of the poor on existing institutions that would keep them both poor and powerless? . . . Or does it mean helping the poor to organize at the family and community level to take greater control over their lives and health?" (40).

It is important to make a distinction between genuine community participation and more limited versions. To be genuine it must be based on truly voluntary involvement as well as a sense of responsibility to the community at large. And, very important, there must be a real devolution of authority and power as well as responsibility. For example, participants must be able to influence such things as the setting of priorities, the selection and dismissal of health personnel, budgetary allocations, and opening hours of health facilities. A situation in which community representatives are included for show ("window-dressing"), while the real power continues to be exercised in centralized and traditional ways, cannot be considered as genuine participation.

For example, during the Technical Discussions one country noted that:

"Local communities are involved in primary health care in one way only, that is by looking for the availability and accessibility of health services. Through village councils, requests are made; such requests oftentimes convey the needs of the people. At central level, it is then known that people in a particular region would like to have a dispensary or a health centre or a village market and so on, but even there there is very little involvement."

Unfortunately, this case is not atypical. Different countries have different ways of organizing authority and different degrees of popular involvement in the control and distribution of resources. These factors have a considerable effect on the extent to which genuine community participation can be realized in any particular society.

Distribution of power

One factor of particular importance is the distribution of power. Genuine community participation requires a substantial decentralization of decision-making and power over resource allocation. Yet from the country cited above we have these remarks about decentralization:

"There is practically no delegation of planning, decision-making, and financial control to the local level. An increased delegation of control will give rise to problems in that there are people of different backgrounds at local level, that is, officers not belonging to the same discipline. People may then not accept responsibilities and inevitably they would return the power to decide to central level. An increased delegation of control will not be of much use in the present context unless the staff at local level is trained or reoriented on the basis of the objectives, and even there it has been observed that objectives at central level and local level differ."

This frank reply went on to say that delegation or decentralization would only be effective when a team spirit developed and there was better recognition of common goals at all levels. The current lack of team spirit was due to clashes between different disciplines and ideologies.

Organization of authority

This case underlines the importance of the overall political and economic context and the organization of authority in a society (33). The structure described might be characterized as centralized and fragmented—one of the most difficult contexts within which to achieve genuine community participation. On the other hand, a decentralized yet cohesive context could be expected to foster and encourage real community involvement. Indeed, health systems with a strong basis of community participation do show a high degree of decentralization of authority, yet link the local level through regionalized structures to

national standard-setting functions.¹ Interestingly enough, in national contexts in which this kind of authority structure does not obtain, only relatively isolated projects emphasizing a high degree of community involvement seem possible.

In favourable national settings, countrywide efforts to give reality to the phrase "health by the people" will be possible. In situations with a harsh oligarchy or dictatorship in control and lack of trust between the government and many sectors of the population, especially urban workers, farm workers, and the poor generally, it may be detrimental to the people's well-being to encourage any kind of officially sponsored community involvement. In such situations, there could only be pseudo-participation under official auspices. For example, in one country where there was a dictatorship (now replaced following a revolution), a large health service project involved a system whereby health priorities were determined by the local communities and a newly trained corps of auxiliary health workers—not chosen by the local communities—were sent in from outside. The communities cooperated but never became fully involved for, among other things, they feared that the new health workers were a group of secret-service spies or part of an information network that would enable new taxes to be collected by the central government.

In such situations, it may be that only small projects under voluntary auspices could make any real contribution to development. These will be high-risk endeavours and many may not succeed, but the few that do will be inspiring indeed. There should also be some kind of network of contacts and exchanges of experience between such small voluntary projects. While this approach ignores the overall health care system, in certain exceptional circumstances it can be advantageous to work at the periphery and avoid the influence of a bad system. In this way, new forces for the transformation and reorientation of the system can be encouraged.

Types of Community Participation

It may be helpful to consider five general types of community participation:

(1) The participation in development efforts, not only at all levels, but also in all sectors, including those of food and water and others which have a (sometimes barely recognized) bearing on health.

(2) The participation at all levels in planning and decisions concerning the structure and functioning of health services.

(3) The provision of facilities, materials, funds, labour, and other support for health.

(4) The provision of health services to others—for example, elderly people in good health, helping to care for other elderly people who need

¹ This appears to be roughly the position in China, Cuba and the United Republic of Tanzania (7).

assistance, or members of the family helping with a patient's physical and social rehabilitation.

(5) Attention by individuals to personal hygiene, diet, and self-care.

Genuine participation at all levels

The first type may be considered the ideal form of participation, representing as it does the genuine participation of citizens at all levels in all types of decision relating to all aspects of development. Although seldom fully realized, it remains the standard against which other forms of participation must be measured.

Participation in health activities

The second type is similar to the first but confined to participation in activities relating to health rather than general development. The challenges of this form of participation are set out in WHO's Global Strategy for health for all by the year 2000:

"A clear national policy may be needed, and even appropriate legislative and budgetary measures, to ensure that individuals and communities can participate actively in deciding on health policy and in guiding the planning, management and control of the health infrastructure and the programmes it delivers. Existing mechanisms may be used, or new ones may have to be created, to make it possible for people to express their views on their community's or country's health system, to take decisions concerning the scope of individual and community involvement in ensuring certain elements of primary health care in the health and related sectors, to control primary health care in the community in which they live, and to participate actively in the control of the other levels of the health system. To fulfil such responsibilities people have to be well informed; to inform them will be an important function of health personnel, who form part of the community and country in which they live and work" (51, pp. 48-49).

Numerous efforts are being made to move in this direction, although the large-scale application of such a policy is perhaps uncommon.

Some countries reported a system of democratic representation whereby elected bodies of citizens have been put in charge of the local health and social services at the district and regional levels. Systems of this kind may, however, fail to achieve a sufficiently wide involvement of people in the improvement of their own health. Also, the health services may become bogged down in discussions on the budget, etc., and approaches to other sectors by the citizens themselves may be limited. During the Technical Discussions mention was also made of the appointment of representatives from the community to the advisory boards of local health facilities.

It is important to distinguish between involvement of individual citizens and involvement of local power groups. In some settings, there may be traditional community leaders, who must be included if action is to be effective. In others, community—as well as regional and national—decision-makers may be dominated by the trade unions. In each

instance, decisions on primary health care priorities and ways of pursuing the health programme will differ. Where there is a strong workers' movement, for example, health facilities serving only specially privileged groups are likely to be severely criticized and considerably more attention to the prevention of occupational hazards may be demanded. Where local structures are themselves participatory, they can greatly contribute to genuine participation. Where this is not the case, however, they may play a neutral, or even negative, role.

Where genuine community participation has been achieved, health personnel can engage more easily and effectively in the common pursuit of local primary health care goals. When the community is asked what it wants, health-related concerns such as pure water for drinking and water for crop irrigation are often given priority over personal health services. However, it is usual for the community to demand some form of immediate attention to disease and injury. Often broader health-related goals cannot be pursued without ensuring personal health services with the appropriate backing and referral facilities within a regionalized system of care.

National plans and attempts at implementing primary health care without real community participation are unlikely to yield the desired results. Initiatives on the part of the local community, bearing in mind the successes and problems experienced in pursuing local primary health care goals, appear to offer a solution to the common problem of lengthy and detailed plans that cannot be effectively implemented.

Provision of resources

The third type of participation is much more limited than the first two and involves the provision of resources by the community itself. A number of countries reported successful schemes of "community self-help" in which local communities have taken responsibility for building or providing space for a local health facility and for furnishing labour or supplies. While this form of participation is very valuable, it should be emphasized that it cannot completely replace the provision of resources from the national and other levels.

It should also be clear that real community participation for primary health care is needed as much in urban as in rural areas. Participation that is used to solicit health resources from rural communities, while hospitals, clinics, etc., are built with public funds in urban centres, is no more than a sham. The health resources of the whole country, including both urban and rural communities, should be equitably drawn upon and distributed to achieve the goal of health for all.

With the rapid rise in urbanization and the more fragmented and sometimes unhealthy life of urban dwellers, it is becoming increasingly clear that a broader involvement of urban dwellers is essential to ensure adequate sanitation and other basic amenities, as well as appropriately oriented and functioning urban health services.

Provision of services

The provision of services is another limited but important type of participation. In many countries each community chooses persons who are sent for training in "front-line" care and then return to serve the community. Where the community chooses wisely (rather than, say, choosing some uninterested relative of a local leader), important links of trust and mutual respect are forged and the relevance of the services is enhanced.

Participation can also take place through various special programmes. Family and community involvement in the rehabilitation of physically and mentally disabled persons has proved very beneficial. In several countries, the experience of planning and providing primary health care for the elderly, not only in institutions but also in their own homes, has proved valuable. Another important life-saving community activity is the oral rehydration of children and others suffering from diarrhoea. People can be trained to recognize the signs of dehydration and help each other to administer oral rehydration salts or at least to know when to enlist the help of village health workers in this connection.¹

Practitioners of traditional medicine are usually trusted by the members of their communities. Community involvement should thus be helpful in bringing traditional and modern medicine together in support of primary health care.

Individual self-care

Finally, there is the involvement of individuals in caring for their own health—again a narrow type of participation but one that is highly important, concerned as it is with life-styles and human behaviour as well as with therapeutic measures.

The results of some recent studies indicate that self-care supported by problem-oriented health education—what has been called "guided self-care" (21)—may have encouraging results. There is already significant evidence that the education of patients to understand the nature of their illnesses and what they can do to help themselves, as well as the education of the public to use the appropriate health services, is well worth careful attention. The achievement of greater individual responsibility in health matters may not immediately result in a reduction of social costs, though professional services may be decreased. The educational effort needed to raise and maintain competence in self-care would undoubtedly prove expensive. The costs in terms of people's time and possible increases in iatrogenic effects must also be taken into account. But there are nevertheless inherent economies in the concept of the patient as the self-provider of reasonable and simple health care.

An additional potential contribution of self-care is an increase in the

¹ See: *Guidelines for the trainers of community health workers on the treatment and prevention of acute diarrhoea* (unpublished WHO document WHO/CDD/SER/80/1).

social accountability of the health professions. It would enable individuals to formulate better judgements regarding the appropriateness and satisfactory nature of health services. Such judgements could be a desirable complement to the "medical auditing" system (26). It is probable that by establishing machinery through which community members are involved in the planning, management, and evaluation of primary health care, the providers of such care will become increasingly more responsive to the needs as perceived by the recipients of services and more cautious in the deployment of limited resources.

Interaction Between Health Personnel and Communities

Primary health care aims at making it possible for individuals, families, and communities to accept much more responsibility for their own health than simply seeking medical care when ill. Both health workers and members of the community will require reorientation to this end. In some communities, particularly well-educated ones, people are already largely aware of what can be done by the individual and the community help with rehabilitation, important as these are. Health series of activities performed by outsiders, for which the community bears no responsibility. In the latter cases, particularly where local resources are very limited, substantial inputs from outside the community may be required to make people aware of their capacity to act together for the promotion of health and well-being.

The training of health workers to support and appreciate full community participation is essential in most countries. It should not be limited to the more clear-cut concerns, such as self-care and family and community help with rehabilitation, important as these are. Health personnel must also learn about hazards in the workplaces of their countries and how workers of all kinds can learn to avoid such hazards. They must become aware of what local women's groups feel about certain subjects of special concern to them, such as excessive medical intervention in the birth process. Above all, they must learn about community organization and change if they are to be successful in fostering broad promotive and preventive action for health.

Although physicians and community health supervisors in many areas have been entrusted with stimulating community participation, they often lack the training for this task (see also section 6). It has been suggested that they should turn to the social sciences to gain a better understanding of community participation and ways of fostering it, but, while this may be helpful to some extent, it will not yield any easy answers. With a minimum of formal knowledge in the social sciences, health personnel can do a great deal themselves, simply by getting out of their offices and into community centres and people's homes and workplaces to learn about the real and perceived needs and demands.

The problem of maintaining active community involvement beyond the first stage of curiosity and enthusiasm is also widely recognized. It was suggested at the Technical Discussions that if the health system rests

on community decision-making and control this will not be a problem, since real power will encourage responsibility. If this is the case, then communities will lose interest only if participation is not accompanied by true responsibility.

* * *

To sum up, the positive value of community participation is now widely recognized, but in practice much remains to be done. Health personnel, especially at the district level, must be trained and gain positive experience in encouraging genuine community participation at the district and local levels. Health leaders at all levels must be mobilized to encourage community involvement, and individuals and communities must be enabled increasingly to assume direct responsibility for matters affecting their own health and welfare. In all these efforts there clearly will be a continuing need for further experience and exchange of information.

6. Manpower

In many countries, the most critical manpower problem continues to be the sheer insufficiency of persons knowledgeable in health matters. This deficiency is usually greatest in rural areas and among the poor and disadvantaged in urban areas.

An important feature of the primary health care approach in attacking this problem is its emphasis on the role of individuals, families, communities, and traditional local health resources in promoting and creating better health. The community itself is thus transformed into a significant health manpower resource. Many of the possibilities for tapping and mobilizing this resource, including guided self-care and community self-help, have been considered in the previous section. An especially important principle in this regard is that the best use of limited manpower resources is made when the *least* trained persons able to perform specific tasks adequately are the ones assigned to perform these tasks.

But the mobilization of this community potential requires appropriate information and adequate motivation for action, as well as leadership and resources. Although these may already exist in some areas, profound changes are being considered and undertaken in the health system in many countries in order to promote, facilitate, and ensure the necessary mobilization at the local level. In most cases this task requires a major redefinition of the roles of existing health and health-related personnel, the development of new types of personnel, or both.

The need for significant changes in the skills and the attitudes of health personnel is widely recognized in both developed and developing countries, although the appropriate responses may vary widely in different national and subnational settings. The reasons underlying current orientations of health manpower were broadly set out in the introductory section. The changes in skills most commonly recognized as desirable are: a broadening of skills from the mainly personal, specialty-oriented, curative type to the community-oriented, preventive as well as curative, and restorative type; training in the education and motivation of individuals and communities to encourage behaviour conducive to health; and the acquisition of a broader knowledge of, and

skills in, ways of influencing the many health determinants outside the traditional health sector, such as individual life-styles, the provision of adequate food and shelter, the supply of safe water for drinking, and the maintenance of a safe environment at home and at work.

Equally profound changes of attitude are recognized as necessary, particularly among professional health workers in most countries today. It is not surprising that this issue arose most frequently in the Technical Discussions when the role of physicians in providing support for primary health care was considered. It also provoked lively comment during the closing plenary session of the Technical Discussions, at which the need for radical changes in medical education on an international scale was vigorously put forward as a prerequisite for genuine progress in the development of effective primary health care. These changes require both the modification of basic educational programmes for health personnel and the provision of inservice training in the principles and practice of primary health care. Some of the changes most frequently mentioned were: greater appreciation of the value of preventive health activities; greater recognition of the role of intersectoral collaboration and the importance of a developmental approach to health; the deprofessionalization and demystification of health care technology, with greater emphasis on the importance of guided self-care and the fostering of self-sufficiency, rather than dependence on the health services for handling problems that can be adequately dealt with at the community level; and acceptance of the importance of caring for the community as a whole in the context of a regional health system.

The necessary reorientation of health manpower systems can be encouraged in a variety of ways. The support of national leaders and opinion-makers can be enlisted; roles can be redefined; material or social rewards can make the desired kinds of behaviour more attractive; and appropriate training opportunities can be developed. However, change can also be encouraged from the periphery of the system through well-informed community participation. An active community organization can draw the attention of district health personnel to local needs. Local health workers can be trained to expect and seek out supportive supervision. The expectation of assistance for community as well as individual health problems can encourage health workers to extend their skills and interests in useful directions.

Although there was general agreement on the actual needs, approaches to the adaptation of existing manpower patterns to the demands of primary health care varied widely. A few countries in both the developing and developed worlds indicated that they had already successfully tackled the problem, either through recent changes or through a more gradual evolution of the health system accompanied by the necessary evolution of health manpower. Many countries indicated some relevant action, but also a need for considerably greater effort. Others had not yet undertaken any changes in manpower patterns in their plans for the development of primary health care.

From the wide variety of approaches, it emerges that each country, and sometimes each particular area within a country, will have to make specific choices based upon the historical evolution and present circumstances of its health system and its social, political, economic, cultural, and geographical situation. On the other hand, some areas of common, mutually reinforcing experience have also emerged.

The pages that follow will deal in particular with three important aspects of manpower development—namely, planning, training, and functioning.

Manpower Planning

Plans for health manpower may be developed in a variety of ways, ranging from the formal to the highly informal. Experience in planning for manpower needs for primary health care appears to span the entire range. Local groups have planned for their own needs through informal dialogue, with varying degrees of direct or representative community involvement in the process. National approaches have sometimes been equally informal but the increasing complexity of the task of matching projected requirements with projected manpower development at the national level underlines the need for a more systematic approach, despite the difficulty of ensuring local participation in a centralized and systematic process. Useful approaches to manpower planning are set out in a recent publication (14), and materials for increasing the capacity for planning are available (16).

The planning of manpower development, however, also requires that the particular concerns of primary health care be explicitly considered throughout the process. A fundamental concern is the need for better coordination between manpower development and health service requirements, particularly at the level of primary care. Although this has been the subject of considerable attention in recent years (56),¹ it persists as a significant problem in many countries.

Community participation in the manpower planning process was also considered important. A variety of mechanisms has been tried, ranging from formal inputs to the national level through the various levels of an established political structure and the participation of local representatives in discussions on planning issues, through workshops or other forums, to the indirect and informal representation of community interests by health professionals working in various areas. Consultation of popular opinion through sample surveys has also been tried, but this method lacks the spontaneity and relevance of genuine political participation, including face-to-face dialogue and the collective taking of decisions.

¹ Report on consultation on health services and manpower development, Geneva, 1977 (unpublished WHO document HMD/77.1); and Consultation on coordinated health services and manpower development (unpublished document SEA/Med. Educ./366 of the WHO Regional Office for South-East Asia).

Although it was observed during the Technical Discussions that the manpower planning process should involve other sectors related to health, no information was available on the practical application of this idea. While specific planning for manpower outside the health sector may be quite difficult without really effective machinery for intersectoral coordination, the planning process must pay attention to the health-related functions of all types of manpower, including workers from other sectors, community-supported workers, and traditional healers. Manpower planning for primary health care should thus be carried out in the context of planning for the health system as a whole, and not as a separate process dealing only with personnel working at the peripheral level.

So far we have considered only the process of manpower planning and its scope and context. But manpower support to primary health care implies quantitative, qualitative, and distributive changes in present manpower patterns. Two closely related factors of critical importance are the analysis and redefinition of the roles and functions of various types of worker and the production of adequate numbers of each type.

Roles and functions

The determination of appropriate types of health worker and their respective roles and functions will depend on the setting. But, in the interests of primary health care, it must be directly based on and relevant to community needs, providing for the integration of promotive, preventive, curative, and rehabilitative activities. As far as possible, it should also provide for health and other developmental activities to be integrated at the local level. The range of activities should thus be much wider than that of the traditional 'basic health services', giving due consideration to the role of individuals, families, and communities in self-care as well as to the provision of more skilled services by more highly trained health personnel.

The expansion and reallocation of tasks among new and existing workers is best based on the principle that all health activities should be undertaken at the most peripheral level of the health services that is practicable, by the workers most suitably trained to carry out these activities. Some guidance on tasks and functions in primary health care is available and being used in manpower planning and training at the local level (9; 46, pp. 4-5; 50).

Considerably less attention has been given to the new roles and functions needed at the intermediate and higher levels of the system in order to provide adequate support for workers at the periphery. Some idea of the range of the support activities required can be gathered from the variety of topics considered in this book. Some of the most important management activities at the intermediate level are coordination with communities and with other sectors, the supply of drugs and equipment, supervision, inservice training, and referral. While each of these is considered in more detail elsewhere in these pages, it is

important to consider them also in connection with the definition of functions and tasks and the revision and/or development of job descriptions for health manpower in support of primary health care.

Mention has already been made of the need to consider community resources as part of the health manpower pyramid. There must be further development of the role of individuals and families in guided self-care (21) and in relation to other health manpower. Existing traditional health practitioners must also be considered, and means of enhancing their contribution to primary health care developed where possible. Considerable experience has accumulated as regards the involvement of traditional birth attendants in the organized health system (32). Although there has been less success in developing useful interaction with other types of traditional medicine practitioner, the experience of some countries where there has been a substantial integration of traditional and modern medicine indicates its potential value in extending the range of manpower available for health care (10).

Manpower targets

Once roles and functions have been defined or redefined in the light of the primary health care strategy, and job descriptions have been developed, numerical targets for each type of worker can be determined. Some of the factors to be taken into account are: the capacity of each type of worker, the need of the population for various activities, manpower training capacity, patterns of manpower utilization and turnover, and health system development plans.

While a few countries have indicated that their efforts towards primary health care are now well established, many others have indicated that much remains to be done as regards the revision of their health manpower patterns. Countries with reasonably wide coverage by health services have mentioned some efforts to modify and broaden the roles of certain workers. Several examples were given during the Technical Discussions of the broadening of the role of nurses in midwifery or curative care. Examples were also given of the addition of new tasks in health education or sanitation to the existing tasks of basic health workers.

In countries where coverage by health services is limited, the need to overcome existing severe shortages of health manpower continues to be a major concern and many of them have accordingly decided to develop completely new types of peripheral health worker. These workers are sometimes part of the health services but, more often, part of the community with training and varying degrees of support provided by the health services. Many countries have already trained and deployed such workers; others are planning to do so. The value of continued sharing of experience in these developmental efforts was widely appreciated by the participants in the Technical Discussions. At the same time, the continuing critical evaluation of these developments and their appropri-

ate evaluation and replanning at regular intervals during the implementation process were felt to be important in ensuring that the expansion of health manpower did indeed provide the anticipated health benefits.

Other factors

In addition to the redefinition of roles and functions and the determination of manpower requirements, several other factors require attention. Political and legislative changes may be required to back up changes in the roles of health workers or the development of new types of worker. The development of appropriate career structures, and, in particular, opportunities for career development combined with mobility can be a powerful factor in motivating and maintaining personnel. The importance of the reward system for motivating health personnel has already been mentioned, although changes in this area often have to be considered in a larger, civil-service context in places where most health workers are on government payrolls. It is important to remember that small-minded jealousies, especially in market-oriented health systems, can seriously obstruct both the redefinition of the roles of the familiar types of health worker and the development of new types of health worker. Every effort must therefore be made, through proper instruction and motivation, to secure the support of established groups of health workers for the new division of labour based on primary health care.

Motivation is of particular importance in ensuring the appropriate distribution of the support personnel at the intermediate level who are so essential to the effective functioning of primary health care. Approaches being used include selection criteria that favour persons from underserved areas, financial or career incentives, periods of obligatory work in rural areas, and a variety of other devices.

To sum up, manpower planning for primary health care demands attention both to the planning process and to the specific choices to be made. The process should be integrated with overall planning for the development of primary health care. Consequently, it must take into account the role of other sectors as well as health, and the role of communities and individuals as sources of health manpower. Choices of the roles and functions of various types of health worker, of the numbers required, and of ways of ensuring their appropriate distribution and effective functioning must be made in the light of primary health care needs at the individual and community level, even when the decisions may conflict with the wishes of established special-interest groups both inside and outside the health sector.

Training

A number of general principles that emerged from the Technical Discussions are relevant to all types of health manpower training, and

these will be considered first. Then certain aspects of training programmes for new types of worker, the revision of existing basic training programmes for professional health workers, reorientation training for primary health care, and regular inservice training programmes will be presented.

The question of the relevance of the roles of health workers and of their job descriptions to community needs has already been discussed. The most important consideration for the development of suitable health manpower resources is the relevance of the training programmes, materials, and methods to the tasks and functions to be performed. This, of course, has to be considered in relation to a given time and place, and no specific definition was attempted. However, the growing understanding of primary health care in recent years has stimulated the reassessment of the training of all types of health worker, from doctors and nurses to community workers.

The multisectoral and multidisciplinary approach

Among the factors in training that are most important for the development of primary health care are a multisectoral and multidisciplinary approach and team-work. By its nature, primary health care requires a relatively broad developmental approach in training, as well as more attention to subjects outside the health sector, such as community education, communications, and social organization. While there was wide agreement to this in principle, there was little evidence that training programmes have yet made any significant steps in this direction, except occasionally at university level. It would therefore appear that the practical implications of this approach may require further study before definite conclusions about it can be drawn.

Principle and practice were somewhat better correlated with regard to team-work (12, 49). It was generally accepted that the primary health care team should be broadened to include the community as an integral and respected member. The importance of including various types of traditional practitioner in the health team was also stressed. In many countries, training programmes for auxiliaries and community health workers are regularly conducted by various members of the health team. However, combined training programmes for various types of worker have been much less common, partly because of the practical difficulties created by differences in content and lack of time. Similarly, it appears that there has been only limited involvement of community representatives in training programmes in any form. There is clearly a need for further experience in this area.

The setting

The question of the most appropriate setting for training received considerable attention. From most countries it was reported that primary health care workers at the peripheral level were being trained

either at an intermediate level (district, area, etc.) or locally. The importance of practical, on-the-job training, firmly related to local needs and tasks, was stressed. A few small countries were training primary health care workers at the national level, while others had sent out national teams to conduct primary health care training at intermediate levels. From this diversity of approaches, it is clear that the relevance of the programme was a much more important determinant of its usefulness than its physical location.

The suitability of hospitals and other curatively oriented institutions as settings for primary health care training continues to be the subject of controversy. There appeared to be two quite different views of the hospital: (a) as an institution dispensing drugs and treatment with little concern for community health problems; and (b) as a concerned and community-oriented institution providing a variety of support and referral services to the community, including, but not restricted to, the care of individual cases referred because they present particular problems.

The first view clearly predominated; the second seems to be more often the ideal than the reality. Though it was generally felt that the first type of hospital is not an appropriate setting for training based on community needs and primary health care goals, it was recognized that hospitals are a major health resource in most countries and none should be rejected out of hand. Rather they should be reoriented and developed as centres of active health promotion and prevention under strong community guidance. Their role in primary health care and in training for primary health care could thus be greatly strengthened, and their value as a health resource enhanced. Many examples of ways of reorienting the hospital's role towards primary health care requirements were presented for discussion—supportive supervision; the strengthening of referral to, and active outreach of, hospital outpatient departments; etc.

Instructors

Another general concern was with the provision of instructors for primary health care workers. The existing shortages and inappropriate allocations of health manpower can only be overcome through rather large training or retraining programmes. Usually one of the steps is to increase the number of instructors who have not only the requisite knowledge of health and primary health care but also the necessary training skills. There is a clear need for central and regional teacher-training groups to train existing health workers as instructors. Such groups can also help to develop appropriate training curricula, teaching methods, and materials for various types of training programme. Although programmes may be based on existing educational institutions, close collaboration between instructors and supervisors and between instructors and communities can do much to make training more relevant.

Training new types of worker

Of the several types of training for primary health care to be considered here, the training of new types of worker (usually various kinds of community health worker) is the area in which the greatest experience has been gained in recent years.¹ The processes of defining roles, developing job descriptions, and specifying tasks have been discussed in the section on manpower planning. On the basis of the information acquired by these processes, it has been possible to develop curricula and design training programmes in a number of countries without serious difficulty.

Several aspects of the selection of community health workers were considered. The importance of the community's involvement in selecting those of its members who are to be trained as health workers was widely accepted. In practice, however, such involvement ranges from moderate independence (the criteria used being established by the health programme), through joint selection by community and programme representatives, to absence of direct involvement. Criteria relating to age and educational standards can impose substantial limitations on choice, and it was urged that communities should be involved in the establishment of criteria, as well as in other aspects of the selection process, if it is to be relevant.

A related aspect is the possibility of selecting various types of traditional practitioner for training as community health workers. Although some experience has been gained in the training of traditional practitioners, especially midwives, there appear to have been few attempts to train them as multipurpose primary health care workers, and it is not yet possible to assess the usefulness of this approach.

It was considered particularly desirable in the case of community health workers that they should be trained as close as possible to the areas where they will work. In most of the countries that offered information on this point, such training was being conducted in facilities at the health centre or intermediate level, such as district hospitals. In a few cases, training was actually being conducted mainly at the community level, while in others at least part of the training was carried out in the community.

Materials and methods for teaching and learning

Another area of particular concern was the need for appropriate teaching and learning materials and methods. A few countries have prepared manuals for community health workers and others have adapted material from publications such as *The Primary Health Worker* (50) to their own needs. While there are constant developments in this

¹ See: UNICEF/WHO. *The community health worker: report on an international study and workshop* (unpublished WHO document PHC/80.2); and *Community health workers: report on an interregional study and workshop* (unpublished WHO document SHS/HMD/84.1).

area, other types of teaching material (posters, slides, films, etc.) were usually much less widely available for use by trainers of peripheral primary health care workers. Continuing efforts to expand and improve locally available materials are clearly becoming more and more necessary as training in primary health care is extended. Useful approaches to this problem might be the development of materials by central training groups or, alternatively, more emphasis on the local development of their own materials by instructors, together with additional training in this area.

The training of instructors has already been mentioned but should be re-emphasized here. Most of the primary health care training mentioned is being provided by existing health personnel, many of whom have had no opportunity to develop training skills. Many countries have provided additional training in primary health care to health workers responsible for training primary health care workers. A much smaller proportion have also been able to provide instruction in training methodology. The promotion of greater proficiency in training methods and skills, and, in particular, the use of nontraditional methods emphasizing team-work and social and motivational skills are needed in order to develop more appropriate training for primary health care. Joint efforts by some neighbouring countries to develop centres for training instructors are worth mentioning in this context.

Revision of existing programmes

Most of the principles mentioned above apply to the revision of existing basic education programmes for health professionals, as well as to the training of new types of worker. However, it is usually harder to change existing programmes than to develop new ones. The types of change needed to equip health personnel for new and more effective roles were discussed earlier in this section. The nature and extent of the changes, particularly in the case of professional health workers are, however, conditioned by a variety of conflicting opinions, vested interests, traditions, and difficulties.

Nevertheless, there are numerous well-documented examples of efforts to make significant changes in educational programmes in order to increase their relevance to current health needs and priorities (19). From the Technical Discussions it appeared that such efforts were being pursued to some extent in many countries and that there was constant awareness of the need to accelerate them. Countries reported greater progress and success in improving programmes for auxiliary health workers than in reorienting the education of doctors and nurses, although there has been little systematic evaluation of the effects of these efforts.

The education of nurses and doctors, however, involves much more conflict between the needs of primary care and referral services and between the role of universities and that of health service providers, in addition to the classic clash between individualistic, curatively oriented,

high-technology care and primary health care based on appropriate community-oriented technology and a preventive approach in the interest of broader and more equitable health development. The frequent lack of coordination between universities or training institutions and the health services must be overcome at both the planning and operational levels. The involvement of universities in the implementation of primary health care, as well as training, was suggested as one approach to this problem, and this has been achieved to some extent in several countries. It can also be a means of promoting a broader community-oriented role for the hospital, the scene of most medical and nursing training. Institutions training professional health workers are also frequently criticized for failing to prepare them to work effectively as a team, either with other health workers or with the community.

But, despite such criticisms, training institutions play a crucial role in developing health manpower, and efforts should be directed towards making needed changes without casting them in an adversary role. There was at least some feeling that changes could, and should, be made in medical curricula to improve the preparation of primary health care personnel, without prejudice to the training of specialized personnel for referral support beyond the primary care level. It appears likely that the reorientation of medical education will continue to be the subject of debate and experimentation for some years to come.

Reorientation of existing personnel

A rather more urgent requirement, recognized by nearly all countries actively pursuing primary health care strategies, is the need to reorient existing personnel for new roles in primary health care. This applies to workers at all levels of the health system, including peripheral health workers, health workers in referral and supporting institutions, planners and workers in health-related sectors, and national, intermediate, and local policy- and decision-makers. In other sectors, and among policy-makers and political leaders, there is a pressing need for a clarification of the meaning of the primary health care strategy and its benefits, and for the development of broad general support for primary health care.

As regards health workers, these purposes are also important, but, in addition, there is often a need for specific training and motivation for the assumption of new roles and functions among their regular responsibilities. There may also be a need for specific efforts to motivate special groups, such as doctors, who may perceive primary health care as a threat to their conventional roles. Some form of active motivation and reorientation appears to have been a prominent feature of most successful efforts to develop primary health care.

Inservice training

The final aspect of training to be considered is inservice training. This appears to be frequently neglected, though its importance is now

recognized more and more. It has several important functions. It can be used to improve existing skills or to develop new ones. It may offer opportunities for monitoring activities and providing support for problem-solving. If given on a regular basis, it may be a strong motivating factor, especially when closely linked with a supportive supervisory system, towards improving the effectiveness of health workers. It can also provide opportunities for career advancement and better adjustment to new roles, both of which are important for the morale of health workers. Last but not least, it gives the overall health system greater flexibility.

Several practical approaches to inservice training were reviewed during the Technical Discussions. One is to train supervisors as instructors, equipping them with the necessary skills and materials and giving them a mandate to provide continuing education for those they supervise. This may be done at the latter's place of work or at the next referral facility, in groups or individually, formally or informally. The use of supervisors as instructors was thought to be especially valuable in assuring the relevance of training to working conditions. The use of community members as instructors was also suggested, although experience with this approach is rather limited. Other approaches include the organization of district or regional courses and the use of mobile teams for inservice training. Further experimentation with feasible approaches, particularly as regards workers at the peripheral level, and the development of suitable training materials for this purpose are desirable.

Ensuring the Effective Functioning of Health Personnel

The effective functioning of manpower, however well trained, requires not only a matching of the numbers trained with the service needs through planning, but also an appropriate working environment. This means that personnel must be adequately motivated to perform effectively the tasks for which they are trained, and that they must receive the necessary information and resources to carry out their tasks properly. Yet a look at the functioning of health manpower in a number of countries yields a common list of problems; among them are emigration of trained personnel, a high turnover of staff with withdrawal from the health sector, and low morale and lack of incentive, especially among peripheral health workers.

Bound up with certain aspects of motivation are several management issues that may increase or decrease the effectiveness of trained manpower. Possibilities of career development, training and promotional opportunities, patterns of assignment, transfer, and leave, and some other aspects of personnel management—such as leadership styles—have a direct bearing on the motivation of specific types of health worker. The mode of operation of supply and financial management systems may reduce motivation and make certain work impossible, if needed drugs and supplies or workers' salaries cannot be provided on time.

The availability and use of appropriate information for monitoring the activities of health personnel are also important in ensuring effective functioning. The importance of appropriate studies, as well as information, for routine monitoring was emphasized during the Technical Discussions. Such studies should be developed in ways that are relevant and applicable to policy-making, planning, training, or management in respect of health manpower.

The evaluation of efforts to develop manpower was seen as a very important activity. Although the evaluation of training achievements and of some aspects of health workers' performance is reasonably satisfactory (20), the broad evaluation of manpower development in relation to primary health care has not yet been adequately developed in practice. Such an evaluation should reflect a concern for human dignity and take in human interactions, as well as technical knowledge and skills.

Several aspects of management relevant to the effective functioning of health workers will be considered in more detail in section 8, which will specifically examine the role of supportive supervision in increasing the effectiveness of health workers. However, it is clear from the complexity of the issues raised at the Technical Discussions that, if health manpower is to be used to the best advantage, a concerted effort must be made to deal with the many shortcomings in those areas that together determine the overall effectiveness of health manpower—namely, planning, training, and management.

7. Financing

Whether it is a matter of mobilizing political and community support, training manpower, providing facilities and supplies, or engaging in some other aspect of health development, the question of financial support quickly assumes importance. Even in the industrialized countries where per capita health expenditure from government sources alone may be over 400 times as much as that from all sources in the poorest developing countries (42, pp. 180-181), there is considerable concern about the financing of health services.

While the Technical Discussions concentrated on health system support from the district level to primary health care activities at the periphery, it proved impossible to discuss the financing of the health system without considering all levels of financial support. Thus, while particular attention was paid to increasing local support, it was widely agreed that the adequate financing of primary health care would require a much broader approach. Indeed, many replies from countries and statements by participants in the discussions indicated that the overall availability of financing was a crucial factor in the further development of their health systems.

Several aspects of the subject were treated at the Technical Discussions, the first being the cost of primary health. The principal conclusion on this point was summed up as follows by the Chairman, Dr E. G. Beausoleil: "Primary health care will initially cost more, not less, but it is expected to yield a greater overall return to both health and development."

Starting from that premise, two complementary approaches to the development of adequate financing were considered. One was an exploration of alternative or additional sources of financing, and the other was a review of the present allocation and use of resources to see what improvements could be made. There was general agreement that both approaches were necessary in order to ensure adequate financial support for primary health care.

The final topic presented is the monitoring of health financing. This reflects the concern, expressed during the consideration of each of the topics just mentioned, that the information at present available is inadequate to determine the best financial options open to the health system.

The Cost of Primary Health Care

Since the Declaration of Alma-Ata in 1978, increasing attention has been given to the financial requirements needed to provide universal primary health care by the year 2000. Although available estimates are crude and contain numerous debatable assumptions, they do provide a rough idea of the order of magnitude of the resource mobilization required.

Evidence from existing primary health care projects suggests that substantial improvements in the level of health can be achieved in developing countries at an annual operating cost of US\$1-7 per person at current prices (11). Similar figures of US\$1-3 per capita annually, plus an additional US\$5-10 per person in development or "start-up" costs over a 5-year period, have been used to estimate the global costs of primary health care over the next 20 years (18). These come to a total of US\$49 000 million to US\$103 000 million at current prices. Approximately 25% of this amount represents the cost of keeping up with population growth, and the remainder the cost of providing primary health care to populations at present underserved. Somewhat higher figures have also been suggested, involving about US\$20 000 million in development costs (half of this related to population growth) and an increase in annual operating costs from US\$6000 million to US\$18 000 million by the year 2000, or about US\$240 000 million over the next two decades (13).

Although these figures are awesome in the aggregate, when the per capita costs are viewed in the context of present and projected government expenditure for health, it is clear that there are realistic possibilities of financing health for all through a better use of the expected growth in health resources in all but the poorest of the developing countries. In the poorest countries there can be little doubt that increases in external support will be necessary. But that too is at a level which could be achieved if the political commitments made to the goal of health for all in international forums can be translated into two- to three-fold real increase in donor support to health. Joseph & Russell (18) estimate that between US\$18 000 million and US\$32 000 million in additional donor support for primary health care will be needed, primarily for the poorest countries.

The trends apparent in the global analysis above were well reflected in replies from countries. Those that were implementing primary health care programmes were already facing increased costs and those where such programmes were in the planning stages were anticipating the need for increased resources. One country's reply clearly brings out some of the major cost elements being faced by many others as well:

"The indications are that primary health care will lead to an increase in the total health expenditure. The major factors responsible for the increase have been identified as follows:

- cost of drugs,
- logistic support for the storage and distribution of drugs,
- expanded immunization and other control activities (particularly for malaria and diarrhoeal diseases),

- training of primary health care workers,
- supervision of primary health care workers,
- development of training and reference manuals,
- construction of clinics, dispensaries, etc."

Further discussion served only to strengthen the consensus that primary health care cannot be fully implemented without significant increases in overall financing. This is not to say that some part of the cost cannot be covered by redirecting funds away from unnecessary or duplicative elements in current health systems, particularly at the tertiary level, through more completely regionalized systems, but the primary health care approach requires an initial massive extension and strengthening of the peripheral health infrastructure so that it may effectively promote and support local health action. This means major new costs for the training of health workers at all levels, and for the provision of the necessary facilities and equipment for their support. Even the figures for appropriate low-cost facilities and equipment will be enormous in the aggregate, since there are tens of thousands of communities to be served. Furthermore, operational costs, including the support of large numbers of health workers (even at very low unit costs, and regardless of the source of support) and the provision of drugs, supplies, supervision and referral support for primary health care, will require substantial increases in expenditure above the present level. Part of the initial cost of primary health care will certainly be offset in the long run by smaller increases in the costs of the secondary and tertiary levels of care.

The fact remains, however, that primary health care is the most cost-effective approach known to the realization of the goal of health for all. Although the cost will certainly be more than that of maintaining present health care patterns, this approach is not only capable of meeting the related goals of health development and social justice but is at present, it was agreed, the only feasible means of attaining these goals.

Sources of Finance

While it is clear that some of the costs of primary health care can be met by the reallocation of existing resources, in many countries a serious approach to its financing requires a careful analysis of the possibility of changes in the system used at present. The financing patterns of the different national health systems show a wide variety of alternative combinations. It is particularly important to note the effects of various financing systems on the distribution, accessibility, and use of health services, and on such vital factors as equity, social justice, and self-reliance (1, 23).

It was emphasized that primary health care is not a special new programme but an approach that involves the entire health system. When this is realized, it should be easier to mobilize financial support within the health sector. In addition, awareness of primary health care as a development programme rather than a health sector programme

should facilitate the mobilization of additional resources from other sectors.

Although there are several more detailed frameworks for the analysis of sources of finance, (48, 51) the discussions concentrated on governmental resources, social insurance programmes, voluntary organizations, direct household payments, local community contributions, and national and international transfers.

Governmental resources

Even though the contribution of governmental resources to the overall finances of the health system varies widely from country to country, the government was generally viewed as the most significant agent for primary health care programmes designed to reach the less privileged members of a country's population. Yet, among the poorer countries in particular, even the most optimistic assessment of prospects for increased governmental expenditure on health falls far short of projected requirements. Even with major reallocations of existing resources, many governments appear to be simply unable to finance the development of primary health care from their own resources.

While discussion concentrated mainly on central government spending from general revenues, recent experience suggests some alternatives. In some places, local government taxes have been used in part to support local health services. Elsewhere, local taxes on alcoholic beverages have been earmarked for health purposes. Government lotteries have also been used to bring in money for health. However, the generation of new government revenue through such approaches is usually least feasible in the poorer areas, where the needs are greatest.

Social insurance

The financial contribution of social insurance schemes to health care is substantial in some developed countries and some middle-income developing ones. However, such schemes are commonly restricted to subgroups of the population, often employed urban workers, thus providing further resources to the relatively more advantaged groups within a country. Unless additional resources can be found to finance the extension of such programmes to rural and disadvantaged urban populations, they will provide little assistance where the needs are greatest. It is worth noting that health cooperatives, initiated in some countries by national organizations of peasants, artisans, or the disabled, could be used to extend the coverage of health insurance schemes.

Voluntary organizations

The financial contribution of voluntary organizations is usually relatively small, but their contribution to health is often significant. Such

organizations, whether local, national, or international, often have their own motives and priorities in the allocation of resources, and this factor should be carefully considered when assessing their role in health care. However, they have frequently been successful in diverting their limited resources to the most needy segments of populations and have often made useful contributions to the development of the primary health care approach. It was felt, however, that the nature and extent of voluntary contributions should be carefully coordinated by the public sector in order to maximize the value of their input into the health system.

Direct household payments

Direct household payments for health services are often a significant source of funds, regardless of the extent of government financing for the health system. Even in the rural areas of poorer countries, private expenditure on health may be considerable if payments to traditional healers and drug shops are included. Many governments consider any form of household payment unacceptable or contrary to the concept of health care as a basic human right. However, the potential for supplementing limited government budgets by such payments is considerable, and they may substantially increase the ability of the health system to provide effective health care. Funds can be mobilized even in countries in which health care is entirely the responsibility of the public sector, through periodic insurance or capitation fees, fee-for-service charges, or a combination of these. Fee structures in different situations can also be adjusted to modify patterns of use or to effect transfers of resources from well-off to poorer segments of the population. Furthermore, the possible detrimental effects of individualistic, market-oriented financing on the integration and coordination, as well as the equitable distribution, of the health services can be avoided by adopting collective decision-making, particularly at the local level.

Like most of the other methods of financing, the extension of direct household payments tends to favour the well-off, and in a predominantly private sector health system it may encourage serious inequities and misallocations of resources. However, in the context of a well-coordinated health care system directed by, and responsible to, representative groups of users, its potential should not be overlooked. It is being used in particular in a number of countries to finance the remuneration of community health workers or payments for drug supplies. The possibility of payments in kind in the form of agricultural products, local materials, or labour was also mentioned during the Technical Discussions as another form of direct payment for health care at the local level.

Local community contributions

In most discussions on local financing, the subject of direct household payments overlaps to some extent with that of local

community contributions. The latter range from local government taxes or levies, through voluntary contributions to community organizations and local insurance schemes, to contributions from the revenues of local cooperatives or other income-generating enterprises.

The possibility of using revenue from local taxes has already been discussed. A variety of informal or formal community organizations can help to mobilize local resources. Many countries are promoting the establishment of local health committees, sometimes as a part of the local government system. There is controversy about the form these organizations should take and concern lest their sometimes narrow view of health might prejudice the integrated intersectoral approach needed at the local level. But such groups have been successful in some areas in mobilizing local resources—financial, material, and labour—for the provision of health facilities, housing and remuneration for health workers, and drugs and supplies. There is considerable interest in mobilizing local action through such groups, although the question of the most effective approaches in different local settings needs further study.

Local insurance schemes

Local insurance schemes are frequently mentioned as a method of financing, but most developing countries have only limited experience of them. Unless there is a workable system of compulsory contributions from defined populations, capable of being administered locally at an affordable and definable cost, this method may be difficult to put into practice. A required fixed payment from each household in a community to cover the salary of a community health worker is a simple form of a local insurance scheme that might be feasible in some areas. The costs of drugs could be included in such a scheme, but this would detract considerably from its simplicity.

Local enterprises

Another approach is to use resources from collective local income-generating enterprises. These may be cooperatives, self-help projects, agricultural or industrial production units, or other types of economic unit. A certain amount of the income can be allocated for specific health-related purposes, such as the remuneration of health workers, the purchase of supplies and equipment, or the coverage of local capital costs for health facilities, water supply, etc. There are numerous examples of such programmes but they are, of course, limited to areas where there is some form of cooperative economic activity and an organizational structure for decision-making.

National and international transfers of resources

Although considerable efforts are being made in many countries to supplement governmental resources by mobilizing community and family

resources, great concern was expressed during the Technical Discussions lest these efforts should divert attention from the need to correct the serious imbalances existing in most health systems between the services available to privileged, predominantly urban populations and those available to their poorer fellow citizens. As one of the participants noted: "We should generate resources . . . by the redistribution of the health budgets rather than by calling on the poor villagers to make contributions on a fee-for-service basis or in the form of insurance payments."

Attention was drawn to the comments of a village chief who asked, in a discussion on the mobilization of village resources for health activities, whether the citizens in the capital contributed money and labour for building their hospitals and water supply. These and other comments clearly underline the need for a substantial reallocation of health resources before requests for increased support from those at present underserved can be justified. There is clearly a potential for increased local support, as some countries have already demonstrated. But it is the poorest who are in greatest need and, at the same time, least able to contribute. Thus it must be accepted that increases in local financing can provide only part of the funds needed for the implementation of primary health care.

The fact that most of the above methods for increasing health finances are least feasible where they are most needed—i.e., among the poorer members of society—indicates the pressing need for transfers of resources within each country to ensure equity in the distribution of health care. The same principle must be applied on an international scale as well, for it is often the countries with the largest burdens of poverty that have the least to reallocate. It was the unequivocal conclusion of the participants in the Technical Discussions that a major increase in international transfers of resources from the richer to the poorer countries was essential to achieve the goal of health for all by the year 2000.

Some rough estimates of the requirements for international transfers were presented in the discussion on the cost of primary health care. The strong relationship between health and wealth was noted. Increased economic growth in the developing countries through the promotion of a new international economic order could, it was emphasized, result in significant additional resources for primary health care.

In addition to changes in international economic relations that would encourage economic growth in developing countries, there is a need for a sustained commitment from the richer countries to assist in the financing of primary health care. Long-term commitments to provide resources are needed for proper medium- and long-term planning.

If the replies from countries to questions regarding possible support from richer to poorer countries for the development of primary health care are any indication, the outlook for any increase in such support is grim indeed. Only three of the twelve richer countries replying indicated their willingness to support primary health care in developing countries.

One of the largest of the developed countries suggested, in reply to questions about the prospect of such support, that: "the focus in finance should not be how much, but what pattern of expenditures have significant impact on health status."

A recent analysis of international donor policies and perspectives regarding support for primary health care was only slightly more encouraging (17). While it indicated general acceptance of the need to improve health conditions and support for the primary health care approach, there were several requirements that were felt to be essential to accelerate the flow of resources from donors. These included better information on current patterns, better planning for the use of, and accountability for, the resources provided, the rationalization of the use of resources at all levels to increase efficiency, and improved machinery for matching needs and available resources.

It thus appears that much greater efforts will be needed in both developing and developed countries if political support for primary health care is to be translated into financial resources. Some developing countries expressed concern about the uncertainty of foreign funding and its negative effects on planning. It appears, on the other hand, that improved planning would make it easier to attract external resources. Better coordination of all development funds, including foreign resources, and better allocation, both within the health sector and among development sectors, were recognized by both developed and developing countries to be important requirements for primary health care.

Better coordination of resources was also noted as a means of improving their utilization. This need was recognized at several levels: coordination of major sources of finance, external and internal; coordination of inputs to various health-related sectors; and coordination of various health-sector programmes.

There are many possible sources of finance for primary health care. There appears to be considerable opportunity, if not necessity, to explore new alternatives in this area, bearing in mind the central concerns of justice and social equity. At the same time, however, there are also many opportunities for making better use of the resources already available. Some of these opportunities are discussed below.

Allocation and Use of Resources

Reallocation of available resources

Mention has already been made of the various patterns of resource allocation that reflect present inequities of distribution. Without doubt there is a need for the reallocation of available resources—both governmental and nongovernmental—in ways that better meet people's needs. A more balanced distribution between the primary care level and the supporting and specialized levels is needed. The participants in the Technical Discussions also considered a more equitable distribution

among geographical areas to be necessary, particularly where urban areas offer high-cost services at the expense of access to basic health care in rural areas. It appears that in many countries little progress has been made in correcting such budgetary imbalances in recent years, despite increasing concern for the development of primary health care.

On the positive side there were examples of decisive action. In one country the national health programme and budget had been revised to ensure a health investment policy more in line with primary health care, even though this involved the suspension or postponement of health programmes initiated earlier but considered of lower priority.

It appeared, however, that significant reductions in existing programmes were often considered not to be politically feasible. It was suggested that a less controversial approach might be the allocation to primary health care of all or most of the additional resources available each year, while maintaining existing support and referral services at their present budgetary levels until priority primary health care needs were satisfactorily met.

Using resources more efficiently

In addition to the reallocation of resources among programmes, consideration was given to ways of making more efficient use of available resources. An example was given of how the bed-occupancy rate in a rural hospital was increased by more efficient use of hospital staff. In another country, a study showed that when hospital staff are fed back information on patterns of admission and length of stay, and these are compared with a set of "ideal standards" for each diagnosis, admission rates as well as lengths of stay are cut down, becoming less than those for similar hospitals in which there is no such feedback of information to the staff. This, incidentally, is an example of action-oriented health service research, about which more will be said in the sections that follow. The exploration of alternative ways of using all types of health resources to increase their contribution to the fulfilment of health needs and the achievement of health goals was strongly recommended, especially in institutions such as district hospitals and local health units that must provide direct support to community health activities.

One of the commonest forms of inefficiency in many countries is the failure to allocate sufficient operating funds to allow the efficient use of resources with fixed overhead costs, such as health facilities or manpower. Health workers who have been trained and are being paid cannot be productive if they lack the necessary drugs and supplies to do their work. Vehicles and equipment cannot justify their capital costs if operating budgets do not permit timely repairs or an adequate provision of petrol and supplies. And failure to delegate financial and other responsibility to a managerial level that is well informed about local needs will reduce efficiency by limiting the ability to reallocate resources in relation to changing needs.

Concern was noted earlier about the translation of political will into political action. It has been suggested that decisions on health sector resources are a "litmus test" of commitment to action (37).

Monitoring of Health Financing

A recurrent theme during the consideration of all the above topics in the Technical Discussions was the inadequacy of available information for assessing and improving the financing of health care. There was general agreement that basic information on health expenditure and sources of finance was essential for effective management and decision-making in this area. In the words of the Chairman of the Technical Discussions:

"While it generally appears that countries are spending absolutely and proportionately too little on primary health care, as compared with secondary and tertiary care, in fact we cannot be sure. Our case is often weak because accounting systems reflecting sources and allocations in terms of primary versus other care have not been put in place."

There are, however, examples of national studies in developing countries in which major categories of expenditure and sources of financing have been analysed and evaluated in relation to health policy goals. Partly on the basis of these studies, a methodology for investigating the financing and expenditure patterns of the health sector in developing countries has been devised (27). The need for the wider use of such approaches for planning and resource allocation, policy evaluation, programme implementation, and the projection of future needs in the health system was recognized. The regular evaluation and dissemination of experience in different countries of the financing of health systems based on primary health care was felt to be a valuable means of increasing awareness on the part of decision-makers of options in this area and their implications for the development of primary health care.

The role of WHO and other international agencies in the generation and dissemination of information was particularly noted. It was suggested that WHO should continue to support efforts to strengthen the capacity of countries for gathering, analysing and using information on health financing to improve the allocation and use of resources. This can be done by means of training activities and by collecting and disseminating relevant information based on experience as well as through direct support, where necessary, to suitable studies on the financing and effective utilization of health resources. Such studies should include the assessment of alternative ways of increasing efficiency in the allocation and use of resources, including various combinations of allocations among the health-related sectors (education, water supply, agriculture, etc.).

Previous attempts to relate resource allocation to health policy suggested that there was a need to review the appropriateness of present

financial information and reporting systems in order to improve the monitoring of progress towards health goals. The types of indicators that will be needed to monitor such progress (52, pp. 19-20, 54-56) will require some changes in present information systems. There is a clear need for further development in this area through a combination of national effort and collaborative interchanges of ideas and experiences.

* * *

To sum up, it is clear that although the development of primary health care will increase the effectiveness of the health system in meeting priority health needs, it will certainly cost more than is being spent on it at present. To meet the increased costs, a greater mobilization of community, national, and international resources will be required, as well as an increase in the efficiency and effectiveness of existing institutions and personnel. Furthermore, the proper planning and monitoring of this development will require new approaches to the collection and use of financial information if benefits anticipated from primary health care are to be fully realized.

8. Management and supportive supervision

A recurrent theme in the Technical Discussions was the need to make better use of all available resources—human and material; national, community and individual—in order to achieve a more equitable distribution of health benefits both for countries and for people. Management is the area of knowledge specifically concerned with improving the way resources are used to achieve desired goals. While the term “management” is used in a variety of ways, it is taken here in the broadest sense to include the planning, organization, coordination, monitoring, and regulation of the use of resources within the health system.

There is little doubt about the need to improve the public management of health resources. In the most technologically sophisticated countries, concern for such improvement is very much in evidence. In the developing countries as well, management is a serious concern not only in the health sector but in many other areas of national interest.

Through the years, WHO has paid particular attention to health management planning (43, 44), and many countries have shared in its efforts in this area. The acceptance of the goal of health for all by the year 2000 has further stimulated the Organization's initiative, prompting the publication of guiding principles on the managerial process for national health development (53). Strong emphasis has also been placed by WHO's Member States on the formulation of national health policies and the sustained reinforcement of health leadership (30).

The application of modern management principles to the development of health (and other) systems has led to increasing concern about the relevance and helpfulness of managerial approaches. Certain problems should be considered at the outset—namely: (a) the differences in approach between management for development and management of routine operations; (b) the importance of the sociocultural context; and (c) the scale of management.

Management for development versus management of routine operations

The flexibility needed to adapt activities to different social, political, and cultural requirements and the complications introduced by

programmes that must alter human behaviour in order to be effective call for radically different approaches in management from those used for more predictable and uniform processes. Attempts to streamline management by laying down standards or procedures to follow for expected problems and providing for the referral of more complicated ones will quickly collapse when—as is frequently the case—the “more complicated” problems become the most common ones. Moreover, inability to respond quickly to the specific concerns of special groups, particularly the poor and disadvantaged, may prevent the attainment of precisely those goals that are most desired.

Management in a sociocultural context

Since modern management theory developed in the context of Western culture, many of the prescribed approaches assume Western cultural values. Thus their application in settings where different values are placed on work, for example, or where social group loyalties and work group loyalties have different priorities, or where time is viewed differently, may have quite different results from those intended. Failure to select and adapt management techniques appropriate to the social and cultural environment in which they are used is a common cause of failure. Yet, properly adapted, the scientific, problem-solving approaches of modern management could play a very useful part in improving the use of resources in non-Western cultures too.

Small-scale versus large-scale management

As individuals, whatever our role, we all act as managers of our own time and resources—with varying success. Most people use an intuitive approach in coping with the complexities of daily work and life, and such an approach works reasonably well for millions of small farmers, shopkeepers, traditional health workers and managers of other small-scale enterprises. The principles of management, as we know it today, grew out of the greater complexities of managing large-scale modern enterprises producing both goods and services. But even these principles are proving inadequate in face of the challenge of managing national resources to meet national goals in environments with great political and cultural variety and a diversity of interests and power structures. Long-standing efforts to improve public planning and administration through hierarchical structures with centralized control may even run counter to the kind of measures needed to mobilize, coordinate, and make the best use of a large number of potentially valuable but autonomous or semi-autonomous resources and special interests at the local and intermediate levels.

Although there is an obvious need for new directions in improving management, it is not always clear what those directions should be. Yet,

as we have seen, management of support of primary health care is too important to be left in the hands of "expert" managers only. The participants in the Technical Discussions considered that the implementation of primary health care would greatly increase the need for better management of existing health infrastructures. It is therefore important that innovative approaches to management should be tried out as an integral part of primary health care development, if it is to avoid becoming bogged down in the quagmire of an overburdened and overcentralized bureaucracy.

Previous sections have mentioned the need for new machinery for more effective intersectoral management and coordination, as well as the decentralization and real devolution of authority, responsibility, and resources. Replies from countries stated that peripheral primary health care activities were often being developed with little or no support from the established health services. It was noted by some that structures and plans for such aspects of support as supervision, supply, and referral appeared sound but did not function as planned. Intermediate and local institutions were often hampered in their supporting role by lack of authority over manpower, money, or material resources.

From the discussions there emerged a consensus in favour of greater decentralization and delegation of authority and resources to enable peripheral institutions and communities to develop and manage their own primary health care systems, assuming the simultaneous improvement of managerial capacity at the periphery. The challenge is that of developing management systems that provide enough coordination and regulation of the allocation of resources to ensure a just and equitable distribution according to priority needs and effective use, and, at the same time, promoting sufficient autonomy at the local and intermediate levels to permit most problem-solving and decision-making to be carried out by people who know local needs, on a scale that is manageable. There are definite contradictions and trade-offs between self-reliance and social control, and the most appropriate balance will need to be worked out for each health system according to its circumstances.

As we have seen, the Technical Discussions concentrated on support from the district or intermediate level to primary health action at the periphery. The general concern expressed above regarding the role of management and the need for new approaches arises from the constraints imposed by current management systems. However, specific action can be taken at the intermediate and local levels to increase efficiency and effectiveness even within these constraints. This applies, for example, to supportive supervision and to management of supplies.

The rest of this section reflects the major areas covered in the Technical Discussions. It is not intended to give a comprehensive picture of management issues at the periphery. The management areas considered are planning and evaluation, supervision, other areas of management support including information and research, and, finally, management training for health development.

Planning and Evaluation

Much of the discussion on planning and evaluation was concerned with "Who?" rather than "What?" or "How?". The role of various potential participants in planning—individuals, communities, peripheral health service personnel, intermediate and central health and health-related workers—was reviewed. It was suggested that simple family and community health plans should be developed first to form the basis for further consolidated planning and resource allocation. It was generally accepted that the community should be involved in planning and evaluation at the local level—for instance, through local health councils and social control agencies. The purpose of such involvement is to make communities conscious of their own needs so that they can identify their own priorities in the light of the available resources. If the primary health care approach is taken seriously, local planning for health should be concerned with development. The options available to communities should not be confined to health. It is therefore essential for sectors other than the health sector also to be involved in raising the awareness of communities and in planning with them.

The need for integrated planning and management not only at the local level but at the intermediate or district level was emphasized by several participants in the Technical Discussions. Better coordination in both planning and operations is needed between district health services (particularly district hospitals and other referral services) and peripheral health services and communities. It appears that, to involve communities properly in planning, most of the responsibility for detailed planning should lie at the district level or below, rather than at the regional or central levels of administration (again bearing in mind the need to improve managerial capacity at the periphery).

The principal role of planning and evaluation at the national level was felt to be the establishment and monitoring of norms and the provision of procedural guidelines for use by the more peripheral units. The policy framework for planning and resource allocation could then be established and overall objectives defined. Responsibility for overall evaluation also rests with this level, although the participants favoured the increasing involvement of the intermediate and peripheral levels in evaluation work.

If this represents the ideal, what then is the reality? According to replies from countries, the most common pattern is still a centralized national planning process for health, although in several countries the health services are predominantly a responsibility of the local or intermediate level. One such country with an industrialized economy is considering the further delegation of health planning responsibilities from an intermediate to a local level in order to strengthen cooperation among local health organizations. In a number of other countries there are community inputs into specific aspects of planning such as the improvement of sanitary conditions, the identification of local sites for health facilities, and the selection of community health workers. In a

handful of countries, community organizations have direct inputs into planning through health or development committees, community leaders or representatives, and mass organizations. The ultimate planning decisions in these countries are usually centralized following inputs and reviews from the intermediate and local levels.

Communities are far less involved in evaluation than in planning. In many cases this is because no evaluation has been undertaken, beyond that provided by normal service statistics. Elsewhere political representatives provide the government with some feedback from communities regarding health complaints. In one country, it was stated, lack of both knowledge and enthusiasm at the local level has prevented community participation in evaluation. The general impression is that, in most places, even the modest participation of communities in either planning or evaluation is very far from being achieved. Much more experience is therefore necessary before the most appropriate combination of community and professional inputs into these processes can be properly determined. Nevertheless, it was generally agreed that apathy often develops in the community when the people realize that their "participation" is spurious and does not really determine what has to be done.

The discussion of specific planning issues relating to the support of primary health care was much more clearly based on actual experience. The proper allocation of functions, techniques, and resources to the different levels emerged as an important subject of concern. There appears to be widespread uncertainty about which tasks are to be performed, and with which techniques, at different levels of the health services. This problem is compounded where institutions at the same level compete for highly specialized tasks, together with the associated equipment and prestige. Questions were asked such as: At what level is a full-scale laboratory needed? Which are the most essential laboratory analyses at the local level? Are X-ray facilities needed at the local level? These questions can be answered in ways that are relevant to each situation. For example, several countries reported that standard lists of appropriate equipment and supplies for the local and district levels had proved helpful.

The participants felt that the selection of specific interventions at each level should be based upon well-defined objectives and clear policies. There is a need to review existing policies in the light of primary health care goals, and this may lead to a revision of the roles and functions of different parts of the health system. Particular attention was paid in the discussions to the reorientation of first-line referral hospitals and district level health administrations as pivotal points of support for local primary health care activities. Although, again, there is limited experience on which to draw, a greater involvement of these institutions in planning processes seems likely to improve the quality and relevance of the plans produced and to strengthen the commitment of the institutions in question to increasing their support to primary health care.

Despite more than a decade of efforts to work out approaches to the evaluation of health programmes, most countries appear to ignore such evaluation in practice. There have been some attempts to evaluate the impact of primary health care programmes in small populations, and evaluations of the impact of certain aspects of national health systems have been undertaken in a few countries. However, the cost of systematic large-scale evaluation work can be considerable and it is not clear to what extent the results will actually influence further decision-making.

Health programme evaluation is, nevertheless, a key component of the managerial process, and the guiding principles on the subject recently published state that: "Evaluation is a systematic way of learning from experience and using the lessons learned to improve current activities and promote better planning..." (54, p. 11). It must be emphasized that evaluation can be usefully carried out at every level and should become an integral part of management activities. Much has still to be done to develop more appropriate methods (notably for use by communities and peripheral health workers in assessing local progress) and stronger links between information from evaluations and decision-making processes. Health services research, with its emphasis on comparative "within-country" and "cross-national" studies, is considered particularly important.

Supportive Supervision

With the rapid expansion of primary health care networks, many countries are already experiencing problems in providing technical support and supervision at the periphery. Indeed, even the supervision of much smaller numbers of basic health workers has often been difficult and inadequate. Supervision was accordingly singled out from the many other important management functions for special attention during the Technical Discussions.

The obstacles to adequate supervision, especially in developing countries with limited infrastructures and resources, are well known. They include lack of supervisors, lack of transport and communication facilities, and low priority for supervisory action as opposed to other activities, especially curative ones.

Many of these obstacles increase with distance. At the same time, it is felt that the more limited the skills of the worker, the greater his need for support and supervision. As one participant stated from his own experience, "health auxiliaries working in remote villages show less interest in their job and have a lower output than those of nearby areas". With more and more widely dispersed primary health care workers trained and working, the importance of supervision increases, but so do the obstacles to it.

One approach to this dilemma is to transfer some supervisory responsibilities to local communities, for example, through social control mechanisms. While this has worked well for administrative

monitoring, it cannot help the community health worker to solve problems, however important, for which he is not prepared. It cannot help him to improve his skills nor provide him with technical stimulation and encouragement for his work.

The strengthening of supportive supervision was therefore considered to be of major importance for ensuring effective primary health care. Indeed, most replies from countries took the view that better supervision would increase the efficiency and quality of peripheral primary health care. In addition to its other functions, supervision should provide support both for peripheral health workers and for community needs. It should reflect the joint responsibility of worker and supervisor for the pursuit and achievement of local goals. Supervisors should also be concerned with seeing that essential supplies are available and that supplies and equipment are properly maintained. As indicated earlier, they should play an important part in on-the-job training and in the upgrading of skills and problem-solving ability.

Two major types of obstacle must be overcome. The first is organizational. If supervision competes with curative responsibilities, as is often the case with doctors at the district hospital or medical assistants at the health centre, supervision is usually the loser. In such cases it may be necessary to reorganize roles and responsibilities and redirect the attention of those responsible for supervision to the importance of this aspect of their work, in order to minimize conflict. New approaches to supervision may be necessary: for example, holding joint problem-solving and training sessions at regular intervals when community workers report for replenishment of supplies, or altering the patterns of visits to villages so that there is relatively more contact time than travel time. In some situations, new organizational structures may be needed: for example, the kind discussed in section 3 with broadly oriented, maybe even nonmedical supervision at the district level so that the curative theme does not dominate the whole scene.

The second type of obstacle is lack of resources, particularly for transport and communications. Here again, an innovative approach is needed in order to find new ways of providing the necessary support without depending on resources that cannot be secured.

The provision of supportive supervision presents a substantial challenge in many countries, but failure to meet it is likely to result in inadequate support to primary health care at the periphery. New and better efforts are accordingly needed in this area.

Other Areas of Management Support

Information

The participants in the Technical Discussions agreed that adequate and relevant information is an essential tool for good management at every level. There was much greater concern about relevance than about adequacy, as information- (or at least data-) overloading seemed to be a

common experience. It was felt that data collection should be limited to what is needed for management and decision-making. Furthermore, data must be analysed and presented in forms that are meaningful for decision-makers—i.e., they should suggest appropriate decisions or action.

Another matter of some concern was the need to adapt information systems to the needs and resources of primary health care at the local level. This may require new approaches to the collection and use of information in order to facilitate the involvement of communities and community health workers in monitoring and assessing their own progress. A particular effort is needed to encourage the collection and effective use at the local level of information reflecting the important tasks undertaken at that level. For example, information for monitoring the programme of a community health worker might include such items as immunization coverage in the community, availability of drugs and supplies, and level of community cooperation. The importance of adequate feedback and the timely flow of information between various levels of the health system was also stressed.

Various steps have been taken to increase local involvement in the generation and use of health information. Systems of classifying health problems have been simplified to facilitate their use by health auxiliaries or lay members of the community (45). It has been demonstrated that peripheral health workers can make good use of basic epidemiological tools to improve their understanding of the health problems in their communities. Efforts have been made to arrive at a more systematic collection of health and epidemiological information at the community level, using data-gathering methods that are both rapid and sound.

The adoption of the goal of health for all by the year 2000 has already stimulated fresh thought about information needs and data collection. An expansion of national, regional, and global information resources to support management at every level will be needed for the achievement of this goal (41).

Research

It is widely recognized that managers need to have information about programme activities and levels of health. The importance of generating new information—of adding to knowledge through research on more effective and efficient ways of promoting health or providing services—is not so well understood although efforts are being made towards a better understanding. The participants in the Technical Discussions therefore stressed the importance of appropriate practical research in the field of management as well as that of technology. Such research can be useful in a variety of ways for planning, operating, and evaluating primary health care activities. It can help in assessing health needs or health levels in various population groups. It may help in defining roles and working out the best combinations of activities for primary health care workers and supervisors. It can be used to assess alternative patterns of organization

or to identify operational problems and assess alternative solutions. It can also be helpful in evaluation and in the development of health system support for primary health care. In the words of the Chairman of the Technical Discussions: "Practical research can be of great value as an integral part of the management process, and needs to be encouraged."

Operational management

Although not considered in detail during the Technical Discussions, other areas of management support are also very relevant to health system support for primary health care. Considerable information is available on the broader aspects of health management, but far less information on specialized support areas such as manpower management, financial management, supply management, and transport management. Some of these aspects have already been considered in the sections on organization, manpower, and financing. But the need to strengthen the routine administrative management of personnel, money, and supplies, especially at the intermediate and local levels, is often overlooked. More systematic efforts are needed at the national, regional, and global levels to strengthen support in these neglected areas.

Management Training

Training in management has been a mainstay of health and other development efforts for many years. Much of WHO's support in this area in the past has been for the training of administrators of health facilities, particularly hospitals. More recently, the development of national health services and the primary health care approach have increased the demand for skilled managers and prompted the reassessment of management training needs in various settings.

Most replies from countries and comments by participants in the Technical Discussions agreed that a sustained effort should be made to train managers at all levels, but particularly at the intermediate level. It was suggested that much could be done to improve management even before everyone had attended a management course. In fact, there are various publications designed to assist middle-level managers to improve their skills (3, 29, 31). While the hazards of overdependence on management training were pointed out, it was stated that this would not be a problem as long as the training contributed directly to the fulfilment of managerial tasks.

The question of the relevance of training to tasks provoked considerable discussion. It was felt that the content of training must be related to local needs; the importance of objective-related and task-related training was emphasized. It was also emphasized that training should take place as close as possible to the area in which the trainees would work and should be related to actual situations.

The usefulness of management training also depends on the extent to which organizational considerations are taken into account. Individuals trained outside the organizational context in which they work often have

little chance of applying their new knowledge successfully. Management training can probably be most effective in developing health systems when it is a suitably coordinated component of overall strategies for organizational change.

Participants also mentioned the need to train middle-level management workers, such as community health officers, to provide managerial, supervisory, and logistic support for primary health care. The trainees could be selected from among experienced trained community health workers. Appropriate management training for members of the community (those on development committees, for example) was also mentioned as a form of support to primary health care.

The key, then, to effective management training would appear to be "relevance". Effective support to primary health care at the local level may often require a substantial effort in management training if it is to reach all those who need it at various levels. Such efforts may be most productive if they are a part of planned changes in the organization and processes of management with a view to increasing the effectiveness of the health programme.

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In conclusion, much can be done to improve the performance of health workers and the use of health resources through better management. This will require an improvement in management systems and organizational patterns, as well as the development of the managerial skills of health workers at all levels of the health system through appropriate training. However, to consider management as a panacea in every set of circumstances would be wrong. Management cannot be expected to provide adequate support for primary health care and make it work in every kind of setting. To concentrate on management in countries with, for example, overcentralized and fragmented authority structures and with gross inequities in the distribution and control of resources would tragically detract from the more fundamental transformation of society required for primary health care.

9. Health care facilities, equipment, and supplies

Primary health care is usually first undertaken in a situation characterized by considerable inequities in the distribution of health care facilities and a strong bias in favour of sophisticated curative techniques.

What steps should be taken to remedy this situation? How can the functions of the health services be redefined so that health care facilities provide efficient support to primary health care without usurping tasks that logically are not theirs and without absorbing money that would be more effectively used on tasks performed elsewhere? How can scarce resources be rationally allocated and used at all stages in the development of health care facilities (planning, construction, and operation) so as at least to meet the absolute priority needs and avoid waste? How can equipment be standardized and simplified so that it can be easily maintained and repaired? How can the simplest possible logistics system be developed for the provision of essential drugs and other supplies?

There are no single or wholly satisfactory answers to these questions, but—as the participants in the Technical Discussions pointed out—it is urgent to determine, as soon as possible, in what direction answers should be sought.

Health Care Facilities

It was decided to review current problems and approaches to them according to the stage in the development of a health care facility (planning, construction, or operation) at which they arise.

Health care facilities are essentially only shelters in which health care functions are performed. Until those functions are defined, the real needs in terms of buildings, equipment, supplies, and drugs cannot be identified. There must therefore be a planning process capable of assessing priorities among health problems and of defining the health care tasks required to deal with these problems at various levels. Through such a process some countries are trying to identify feasible and affordable groupings of tasks, thus defining roles and responsibilities for different types of manpower, and then deciding what buildings are needed to accommodate the performance of those tasks,

and what equipment, materials, and drugs are required in order to perform them.

Practical experience has shown that many primary health care tasks can be performed without special buildings—in the home, the school, the place of work, or even out in the open. Nevertheless, some tasks are much more adequately performed in a building designed and built with those tasks in mind. From their own experience, participants in the discussions cited the following examples of the kinds of physical facility needed:

- Treatment, prevention, and rehabilitation usually require rooms for their execution, as well as basic utilities, such as a supply of clean water, lighting, and sanitation.

- Immunization activities require the provision of cold storage at the secondary level and of cold transport to the point of delivery.

- Adequate transport and two-way communication must be ensured.

- Drugs require safe storage.

- Education and training need appropriate facilities, including classrooms and equipment.

- Lodgings may be needed for workers at the primary level.

- In areas with a dispersed population and bad roads, accommodation may be required for women awaiting confinement.

- Shelter facilities are needed for patients coming from remote areas for treatment.

- Community work also requires a meeting room, which can be the same as the classroom for education and training and may belong to a sector other than the health one (e.g., school, church, or village hall).

Within this framework, the supporting role of health care facilities, including the front-line hospital, was examined. It was acknowledged that the hospital could, and indeed would, have a role as a support and a complement to primary health care. Care should be taken, however, in resource allocation to ensure that community-based health efforts and supporting facilities do not suffer. It was appreciated that the role of the hospital in the primary health care context would inevitably be changing and that it was difficult to predict the full extent of that change until programmes had become more firmly established. For example, the "bypass phenomenon" becomes less of a problem for local services as the quality and relevance of care at the community level are improved. In any event, the rigid polarization between partisans of hospital development and those who favour primary health care has little relevance, since both the hospital (albeit in a modified form) and primary health care should be integrated into a convenient local health system, with clearly defined essential requirements in terms of manpower, facilities, equipment, and supplies appropriate to the health tasks to be performed. In emphasizing the importance of rural health care, the increasing problems of primary care in underserved urban and periurban areas should not be overlooked.

One of the recognized problems in health facility planning in many countries, particularly those with market economies, is that of the

multiplicity of decision centres. Sometimes this is associated with positive developments, such as the participation of other sectors and the community itself in the financing and building of facilities. However, it often precludes a reasonable balance in the development of health care facilities sponsored by various owners. For example, in some countries, social security funds build their own network of facilities, many of which would be considered from a national standpoint to be redundant. In other countries, important economic complexes (mines, plantations, etc.) construct and operate facilities without regard to the balance of the local health system. There are also many examples of ministries of education or defence developing conventional teaching hospitals or other specialized facilities that have no coordinated function in the national, regional, or local health systems. This shows the need for more effective cooperation of the health authorities with other sectors both nationally and locally, in order to achieve better coordination between all health-related efforts and facilities.

More effective planning is essential if facilities are to have an appropriate, cost-effective role in the health service system. It is at the point where an overall facility plan is being derived from the health service plan that some of the most costly mistakes are made. The question of task definition for various types of facility arises here, as does that of adequate coordination between different sectors. However, there can be other problems, such as a shortage of basic information. There are several ways of collecting the requisite information. For instance, a national inventory of facilities and heavy equipment, periodically updated by means of surveys, visits, or reports, may provide essential information, covering the whole country, on numbers and types of facilities and their age, present condition, and main problems. However, even where the basic information exists, there is often not the planning capacity within the national health authority to develop it into a comprehensive physical plan relating health service priorities to a plan of action for the development, rehabilitation, and upgrading of facilities. Activities in this area need significant strengthening.

The plan for health facilities does not, of course, exist in isolation, but is a component of the overall health strategy, along with manpower plans, equipment, drugs, supplies, transport and two-way communication. It must also be developed with due regard to the intersectoral aspects of national planning. Experience in some countries clearly demonstrates the advantages of integrating building plans for health care facilities into more comprehensive plans covering the entire infrastructure of communal services for the area concerned. Health care facilities are limited in their effectiveness if all-weather roads, water supplies, and electricity are not available on the spot. The use of "multiservice modules" is another example of comprehensive physical planning and the performance of overall territorial planning in a continuous way.

To achieve the goal of health for all through the medium of health systems oriented towards primary health care, there has to be a

fundamental rearrangement of building and equipment priorities involving new building types, approaches to design, methods of construction, ways of using materials, and modes of implementation. In the Technical Discussions, the comments from countries generally favoured standard designs rather than *ad hoc* solutions. However, the use of standard designs in the context of nonindustrialized countries is associated with certain serious problems. Sometimes the designs are not properly followed, particularly by persons who do not belong to the ministry of health. Elsewhere they have been followed too rigidly. A range of designs is necessary, even for the same type of facility, to allow for regional variations in climate and building materials, and possibly in local customs. Besides, the use of standard designs sometimes tends to promote resource-oriented programmes at the expense of more relevant primary health care programmes that are task/function-oriented or not based on facilities.

From virtually every point of view, the maximum use of locally available building skills and materials is desirable. Conversely, the extensive use of imported skills, materials, and techniques has tended to result in architecture that is out of keeping with local functional requirements, geographical and climatic conditions, and cultural values. Imported materials and equipment are also expensive to buy, use up foreign exchange, and are difficult and costly to maintain and repair. Unfortunately, multinational firms interested in selling sophisticated medical technology wherever a market can be created are often among the forces that jeopardize the establishment of health systems based on primary health care.

The use of local skills and materials obviates most of the above problems and carries the developmental advantage of encouraging local employment and industry. In this context, community involvement through self-help projects was noted time and again to be extremely beneficial. In one country, 50% of rural building expenditure was covered locally. In another, the cost of facilities constructed by the community was only 3% of that of government-built facilities of the same type. On the other hand, as was vigorously emphasized in the Technical Discussions, to require rural communities to furnish materials and labour while everything in urban areas is provided out of tax funds is an all too frequent form of imbalance that can destroy confidence in the primary health care approach.

There are no general rules about which types of facility should be promoted or discouraged; each country should identify its own imbalances and strive to correct them. Usually it is the primary level of a health system that has to be built up first and then the more central supporting levels. The technical and managerial cohesion of a balanced health system is relatively easy to achieve by applying the principles of regionalization (4). This is, for example, the only means of reducing the anomalous bypassing of peripheral units that leads to their underutilization and to the overutilization of the larger and more costly referral facilities.

It was this type of finding that led to the analysis of the entire health service system in each of the countries involved in recent case studies of health care facilities. The lessons thus learnt have been abstracted and communicated to the appropriate decision-makers in the countries concerned; they have also been reviewed at national workshops, where they provided a basis for recommendations for action.¹ The participants in the Technical Discussions noted that the development of national initiatives of this kind would be the best basis for reasonable decision-making in the planning, building, and operation of health care facilities. They would indicate the areas where support is needed and develop the capacity to absorb and adjust the transfer of appropriate technology in accordance with local needs and opportunities. The discussions also showed that national experience can be pooled and exchanged among countries, most often bilaterally, but also on a regional basis (as in the Western Pacific Region of WHO) or a subregional one (as in the Andean countries and Scandinavia).

Equipment

Because the provision of health services of an acceptable standard depends on the availability and proper maintenance of the right sort of equipment, careful attention must be given to the selection, maintenance, and use of equipment in any health care facility, whether it be a dispensary or a referral hospital, and by any health care team.

Two fundamental principles, recalled during the Technical Discussions, should underlie the choice of equipment for all health services, whether in developed or developing countries:

- all equipment should be the simplest that will perform the function for which it is required.

- The equipment chosen should be that which requires the least amount of maintenance and for which maintenance resources will be locally available (6).

These principles have been stated time and again, yet, because in practice they are so often ignored, no apology is offered for stating them once more. As already mentioned, they are applicable to health service equipment anywhere in the world, but particularly in countries in which funds may be more limited, in which there are very few skilled maintenance personnel, and in which, therefore, failure to adhere to them can easily render expensive equipment virtually useless in a short time. Moreover, since in less developed countries there is a great need for preventive health services, the decision to divert funds from them into the provision of expensive facilities and equipment that can serve only a relatively small part of the population is one that should be actively discouraged. The importance of weighing the technological

¹ Case studies—approach and preliminary conclusions (unpublished WHO document SHS/SPM/80.5).

imperatives in equipment selection against economic efficiency has been more widely discussed elsewhere (22). Also, the need to ensure the relevance of the equipment selected to the functions to be performed and to local conditions has been exhaustively discussed in recent years in connection with appropriate technology for health.

In this context, appropriate technology for health may be defined as scientifically sound, safe, effective, and acceptable health-related procedures and tools, accessible to all and available at a cost that communities and health administrations can afford. It should be cheap, simple, and, when used at the primary level, supported by the entire technological spectrum at the higher referral levels of health care. With these considerations in mind, continuous efforts have been made in a number of countries to promote and develop a consistent package of health technology geared to the needs of primary health care. In the pursuit of this goal, several low-cost techniques have now emerged. Systematic action to coordinate isolated efforts into national undertakings with the emphasis on self-reliance has yet to take place, however.

On the basis of the experience of participants in the Technical Discussions, the following conclusions concerning equipment were reached:

- For life-saving action, for instance, haemostatic devices, oxygen, and assisted respiration equipment will be needed. Some items could be available at the secondary level and some will be readily available at the primary and even the household level (e.g., a home-made tourniquet).

- Simple kits and instructions in the hands of a trained member of the community will facilitate first-aid in the home and the community.

- Access to a referral level of health care with diagnostic and therapeutic equipment (e.g. laboratory, radiological, or surgical) was considered necessary.

- Such access in turn requires adequate transport and means of communication, as does supportive supervision.

- Simple recording and reporting is a function that, at the primary level, requires some stationery (possibly including practical, standard forms) and a small storage place.

- For community education and even for professional inservice orientation, the equipment needed at primary health care level can be simple: posters, pamphlets, flannel charts, etc. However, access to mass communication media is desirable since these can transmit centrally prepared programmes that may reach remote areas. Mobile film units are known to make a special impact.

The first step in equipping a new health project, whether it be a very small one such as a rural primary health care team or a large one, such as a referral hospital, is to draw up a systematic schedule of all the equipment that will be needed for the accurate performance of the functions assigned to a particular health team or facility. When making such a schedule, it is easy to overlook items and, if possible, a check-list

of some kind should be available.¹ In any case, there should be full consultation with future users to help ensure that nothing is forgotten. It is helpful to divide equipment into groups for its proper purchase and procurement, and consideration must be given to the various sources of supply. As a general rule, every effort should be made to locate possible domestic manufacturers rather than buy from abroad. For many countries, the advantages of using local manufacturers include the probability of lower costs, freedom from problems of import and foreign exchange regulations, and the possibility of direct liaison with the manufacturer so that the design and spare parts can be made to suit particular requirements.

As was noted during the Technical Discussions, the most important factor in choosing suppliers of equipment is whether or not proper arrangements for maintenance can be made. This is even more important than the question of price; there is no point in buying a piece of equipment cheaply if after a few months it breaks down through lack of maintenance and lies idle indefinitely because there is no one to repair it. An important factor to take into account is where the workshops for maintenance services are based and how quickly they can be reached in the case of a breakdown. A generous allowance for spare parts should be made in the equipment schedule, and adequate stocks should be ordered at the start. As each piece of equipment is listed, thought should be given to the spare parts it may need.

Especially in the case of equipment (including vehicles), lack of standardization and of control over purchasing leads to such a proliferation of types and manufacturers that the stocking of adequate spare parts is impossible. For more sophisticated medical equipment, maintenance personnel are often trained by the supplier, and they may be unable to repair the equipment of another manufacturer. The problem of standardization is sometimes further complicated by gifts of equipment from donor agencies, by trade agreements between countries, and by the obvious need to find the best value for money in the market. In this last respect the tendering system of purchasing leads to over-diversification if lists are not restricted.

Drugs and Other Supplies

The Technical Discussions emphasized the need to get essential supplies (as well as equipment) to the spot where they are needed, in good order and in proper time. A number of serious problems were identified. Often in the poorer countries there is an utter lack of essential drugs and other supplies. Sometimes these items are available at the national level, but because of overcentralized authority structures, poor planning, poor communications, inappropriate storage, or inadequate

¹ See: TORFS, M. E. *Provisional reference lists of equipment and supplies for peripheral health services* (unpublished WHO document SHS/75.2).

transport they are not made properly available at the local level. When materials, especially drugs, arrive in a deteriorated condition, the credibility of the whole primary health care approach may be weakened. Thus proper purchasing, storage, and distribution, including a "cold chain" for vaccines and other sensitive pharmaceuticals, become essential. The supply of materials should also be considered in a wider, intersectoral way by health personnel, for if the community's priority is housing and social utilities and wood, cement, and iron bars fail to arrive when needed, credibility will again be lost and the result may be to discourage all developmental efforts, including others relating to primary health care.

The discussions emphasized the need to know the real and perceived needs at the local level in order to ensure relevant material supplies for primary health care. Once decisions have been made about what supplies are needed by personnel and facilities at the primary health care and supporting levels to carry out their assigned functions, a logistics system must ensure the timely availability of these materials. This will require the procurement of adequate amounts to meet local needs, adequate storage to ensure the maximum useful life of supplies (this is particularly important in the case of materials such as vaccines and certain drugs that require continuous cold storage), timely distribution to the point of use, and adequate inventory control and feedback, including mechanisms for resupply and redistribution according to varying needs.

Replies from countries mentioned many different problems and some successes in improving logistics systems for support to primary health care at the periphery. A few examples are listed below:

—The most widespread concern was about *supplies of drugs*. It is thought that the public will lose confidence in primary health services if essential drugs cannot be provided regularly. The poor provision of essential drugs will lead to an increase in the use of referral facilities, and their consequent overcrowding, and will greatly reduce the ability of the local health system to function effectively in its promotive, preventive, and curative roles.

—Inadequate roads and poor *transport and communications* often make the distribution of supplies difficult.

—*Centralized decision-making* makes it difficult to adjust supplies to local needs and to ensure timely resupply. An extreme example was the requirement in one country for district and regional health officials to obtain approval from the national ministry of health before their monthly supplies of aspirin could be replenished.

In many countries "cold chain" requirements and machinery for monitoring are being worked out to ensure effective maintenance of equipment and the supply of perishable drugs and vaccines.

—Some countries have found it easy and helpful to compile lists of *essential drugs* to be maintained at the local and district levels.

While drugs alone are not sufficient to provide adequate health care, they do play an important role in protecting, maintaining, and restoring people's health. However, many pharmaceutical products are still mar-

keted with little concern for the different health needs and priorities of individual countries. The promotional activities of the manufacturers have created a demand greater than the actual needs and sometimes there are no proper indications as to side-effects and appropriate use. Since up to 40% of the total health care budget in developing countries may be spent on drugs, the result has been an increase in the cost of health care or a reduction in the funds available for other health services. The cost of drugs has affected even the affluent nations, and their governments are increasingly involved in establishing effective machinery to reduce unjustified drug consumption. In the developing countries the problem is magnified by limited resources, a shortage of trained health personnel, and the lack of organized drug policies. On the other hand, in the least developed countries, in which communicable diseases and the lack of elementary health care are the major concerns, large segments of the population are in urgent need of essential drugs.

It seems clear that, to make the best use of limited financial resources, the available drugs must be restricted to those proved to be therapeutically effective and acceptably safe and to satisfy the health needs of the population. These have been called "essential" drugs to indicate that they are indispensable to meet the health needs of the population. The notion that the number of really necessary drugs is relatively small is supported by experience. Several developing countries that have adopted limited drug lists report good acceptance by the public, as well as favourable medical and economic results. Lists and formularies with a limited number of drugs are also successfully used in many developed countries. It should be noted, however, that, because of the great differences between countries in health needs and conditions, the preparation of a standard universal drug list of general applicability and acceptability is not feasible or possible. Each country therefore has direct responsibility for evaluating and adopting a list of essential drugs according to its own health policy (55). This also applies to a large extent to health care facilities and to equipment and other supplies. The participants in the Technical Discussions therefore recommended that all these areas of support for primary health care should be further examined and that available national lists and guidelines should be more widely publicized.

10. Concluding remarks

The ever-widening process discussed in this volume—namely, the pursuit of the goal of health for all by the year 2000 by means of health systems based on primary health care—is one that must continue. It is with this in mind that these concluding remarks are offered. They are in three parts: policy considerations; needs for action and research in respect of each of the seven topics reviewed by the working groups at the Technical Discussions; and recommendations on the support process.

Policy Considerations

Now that many countries are developing primary health care programmes, it is becoming much clearer that national health systems must encourage and strengthen direct support for these programmes at all levels. Action on policy at the national level can make a very big and positive difference. However, the reorientation of national policy must find a response in the form of a corresponding shift in direction at the intermediate and local levels within each country, thereby creating the context in which support to primary health care can have real meaning and real results.

One way forward is for countries to analyse the problems faced at the intermediate level of the health system, where national policy is being transformed into a plan of operations aimed at developing support for primary health care. Such an approach could be most effective in singling out the main problems and possible solutions at the level where primary health care activities are being implemented and the need for greater support is already apparent. The main purpose should be to help intermediate health staff to develop and implement plans of action and thus learn from practical experience. A secondary purpose would be for senior national management staff to learn how they could strengthen the support given at this level.

Action on the Topics Reviewed

Organizing health system support for primary health care action at the periphery

Beyond the kind of general policy decisions and political action needed to create the conditions and goodwill for support of primary health care, there are a number of more specific measures that should be stressed here.

In some instances, it may be desirable to carry out a survey of the concepts of primary health care held by health sector personnel at all levels and by persons in key positions in other sectors. On the basis of the findings, specific educational strategies and programmes could be worked out with a view to correcting misconceptions and reinforcing positive views.

In most countries it will be desirable to reconsider the whole complex of factors motivating people to support (or not to support) primary health care. Specific action should be considered, such as redirecting the flow of resources so that proportionately more go towards primary health care, or increasing incentives for primary health care work rather than highly specialized work. There may be also be a need for practical research on the more subtle aspects of motivation—for example, determining which groups of personnel are likely to respond positively.

In most situations the structure of the health services themselves will have to be re-examined. All concerned—from health system planners to communities—should consider what changes will be needed to permit: (a) personal health care workers at neighbourhood level to develop and pursue a health plan for each member of each household within their assigned geographical area; (b) community health workers to develop and pursue adequate preventive plans in relation to environmental health, health education, school health, and workers' health; and (c) higher level health institutions (such as health centres and front-line hospitals) to provide referral and supportive supervision.

Intersectoral support for primary health care

It would be highly desirable to have, within each country, standing bodies with real power to inquire into, influence, and effect plans, programmes, and specific action in any sector, where these have a bearing on health. Ideally national health councils and national health development networks should fulfil this role, but that may not always be feasible. In any case, *ad hoc* bodies could be developed to survey the many possibilities that exist for cooperation between, say, agriculture and health as regards food supply and nutrition; labour, industry, agriculture, forestry, mining, and health as regards occupational hazards; education as regards teaching of self-help and prevention; and so on.

From the Technical Discussions it emerged that, although possibilities for intersectoral cooperation and support to primary health are many, the gaining of actual experience and exchanges of both negative and positive experience in this field have been far too limited. The possibility of preparing comparative case studies to facilitate such exchanges should be considered.

Community participation

The political, economic, and cultural circumstances of each country greatly influence all aspects of support to primary health care. This is especially evident as regards involvement of the public. If the traditional structure is one of highly centralized "paternalism", genuine involvement on the part of communities or of unions and other voluntary associations at the local level will not be forthcoming. Yet such involvement is essential to the primary health care approach. Spurious participation in the form of "window-dressing" will not get the job done; in fact, it will inhibit and delay the realization of primary health care goals, for real understanding and effective action by members of the public hinges on a genuine devolution of authority and responsibility—in short, social control.

Once the concept of community participation is properly understood and the conditions for its achievement are realized, the possibilities for improved health, as experience has shown in a number of countries, are truly marvellous. There is a release of creative human energy that can be directed into mass campaigns, the well helping the sick, the provision of materials and labour for primary health care facilities and programmes, guided self-care, ensuring the timely use of health services, and other forms of positive action.

While there is a good general understanding of the relations between effective community involvement and propitious political and economic conditions, there is a need for comparative case studies and other research to show the limits and possibilities of such involvement in different contexts. There is also a need, within given contexts, to study how medical and other personnel at district level can be made more tolerant and appreciative of genuine cooperation by the community, encouraging its participation in decision-making on such matters as programme design and execution, appointment and dismissal of personnel, and budgetary allocations. This leads us to the question of manpower.

Manpower

The point just made about community involvement and the need to make district level personnel more understanding is only part of a whole reorientation of attitudes considered necessary by the participants in the Technical Discussions. As one participant put it: "We have to reeducate the educated before we can succeed in educating the uneducated." In

other words, only suitably trained and oriented health personnel can contribute to the proper training of primary health care workers at the periphery.

One important suggestion was that the workers in question should be trained to: (a) view the population and area they serve from an epidemiological standpoint; and (b) demand proper supportive supervision in dealing with problems on this basis.

In general, the principle should be followed that the *least-trained* person should perform a given task if he or she can do so adequately. If this principle (based on experience) were completely followed, it would be hard in most situations to speak of a shortage of health manpower.

The importance of on-the-job and other forms of inservice, task-oriented training cannot be over-emphasized. Sometimes mobile teams can be used to inspire and refresh both the teachers and the taught. Ordinary members of the public can profitably be included in such training to ensure proper attention to human relationships as well as technical matters.

Financing

Not only should a proportion of the overall health service budget of each country be used to support primary health care, but there should be new accounting and budgeting systems that will adequately reflect the actual support going to primary health care. Most countries do not know what is spent on primary health care as compared with other aspects of the health system. WHO has supported some projects to elucidate this question; these should be increased in number and the findings widely disseminated.

Since increased funding for primary health care can be detrimental to the high-priority support and referral components of the health system, financial support for primary health care is likely to require additional appropriations. Only a portion of the additional funds needed may be expected to come from local communities. It was considered important to emphasize that primary health care is not a special new programme but an approach involving the entire health system; such a view should make it easier to mobilize financial support within the health sector. Furthermore, if primary health care is seen as a development programme rather than a health sector programme, this will facilitate the mobilization of additional resources from the other sectors for its support.

The cost of implementing primary health care exceeds the financing ability of many countries. Thus firm and sustained international commitment to financial assistance for primary health care is essential. Long-term commitments to provide resources are needed to permit proper medium- and long-term planning. The need for all development funds, particularly foreign aid, to be coordinated through a single governmental body was noted as a handicap to the adequate financing of primary health care.

Management and supportive supervision

While national plans, standards, and assistance, including the reallocation of resources between the regions of a country, are important, as are plans and management within each region, the key to proper primary health care action at the periphery rests in the hands of managers and other personnel at district level. They must provide guidance, training, equipment, materials, drugs, and supplies that are no more and no less than what are needed to meet local needs and demands.

The participants in the Technical Discussions agreed that in most countries the training of managers and other personnel at district level in the supportive management and supervision of primary health care is woefully inadequate. Training programmes should be established so that relevant support will be given to front-line workers and to the coordination and two-way flow of information and of patients between the periphery and the district level, and the regional centre so that proper follow-up action can be taken. These programmes should encourage health managers to facilitate, if not take a leading role in, intersectoral action in support of primary health care. In addition, they should encourage district-level personnel to foster genuine community involvement in the managerial process, including planning. They should also foster a helpful attitude towards local personnel requesting supportive supervision. Finally, it is essential that the training should be geared to the local epidemiological situation and include clear presentations on its history, political economy, culture, and socioenvironmental conditions in so far as these have a bearing on health in the district, the region, and the country.

Special projects might be launched to see in what ways practical research on health services could be of use in the decision-making process, especially to managerial and other personnel at district level.

Facilities, equipment, drugs, and supplies

The tide of irrelevant sophisticated medical technology must be stemmed if the primary health care approach is to be realized. Buildings, equipment, and material must be relevant to the performance of the tasks required to meet local health needs and demands. Often a prestigious, expensive, and irrelevant building or piece of equipment, or a supply of a new but unnecessary drug, is accepted because of pressure from external commercial interests that find it profitable to push their wares in a highly competitive world market. National, regional, and local health planners and managers must learn to resist such pressure. Sometimes these items arrive as the result of well-meaning, but misdirected, aid. Here again, the pressure must be resisted. In general, as regards the acquisition of material goods for primary health care, the periphery should influence the centre. Local communities should have the dominant voice in this area, showing a healthy

degree of scepticism as to the value of hospital-based medicine and ensuring that supplies and equipment are relevant to the accomplishment of primary health care tasks.

Countries have found it helpful to draw up lists of essential drugs and supplies that are locally relevant, and an efficient logistics system is considered necessary.

International associations of planners and architects of health care facilities have been helpful in developing guidelines for buildings where primary health care work will be carried out. Other bodies could be encouraged to do the same for equipment and drugs.

A special problem of considerable concern to participants in the Technical Discussions was the proper maintenance of buildings and equipment, including vehicles. This is especially difficult when different sources of manufacture and supply are involved.

Recommendations on the Support Process

The primary responsibility for fostering understanding of, and support for, primary health care rests with the national level of the health system in each country. In the Technical Discussions and in this publication, the emphasis has been on the intermediate or district level and its support to primary health care work at the periphery of the system. This emphasis is entirely proper, for it reflects the need to direct health services and intersectoral action for health to the places where health problems arise—the home, the place of work, the community in general. It also reflects the need to encourage, indeed pursue, the direction of health activities essentially by the people themselves and their collective forms of organization—community bodies, labour unions, other voluntary associations, etc. But it is the national authorities who must launch and follow up the processes whereby primary health care will become basic to the whole national health system.

Two kinds of national body in particular can help to create the necessary goodwill towards primary health care. A national health council can serve as a forum for intersectoral policy within which the concept of a health system based on primary health care can be clarified and the search for technical solutions encouraged. A national health development network can bring together the available technical and other resources and foster the development of scientifically sound, yet down-to-earth solutions to local problems. This body can engage research workers and others with the necessary expertise from the country itself and perhaps call on technical cooperation through WHO and—this is particularly important—a whole range of international nongovernmental organizations with expertise in particular aspects of health system reorientation, such as manpower development, health systems research as part of the decision-making process, facility and equipment design, essential drug supply, intersectoral action, or community participation.

Only through action at the country, intermediate, and local levels can understanding of primary health care and its support in different national settings be improved. But there is an important need to share down-to-earth experience, both positive and negative, between districts and regions within countries, between groups of countries, and indeed throughout the world. The collection of information on the basis of detailed historical case studies should therefore be encouraged and forums provided for the exchange of this information. The process of improving both conceptual understanding and practical experience of primary health care must be vigorously pursued, with special emphasis on action at the local level and on the exchange of experience and ideas, if the goal of health for all by the year 2000 is to be realized.

In every forum, whether it be a national health council, a national health development network, or a special meeting to exchange information on case studies, as suggested above, there may still be a need to put an end to various myths concerning primary health care—such as the notion that it is second-class care for rural areas. It may also be necessary to disabuse people of varying levels of sophistication who continue to take the traditional view that the only really high-quality health care is the passive, hospital-based, curative kind.

This kind of confrontation and clarification has to extend beyond the meetings of formal bodies and the meetings and training sessions of health personnel. The misconceptions of the general public about health care can be dispelled in at least two ways. First, and most important and practicable, local people should be involved in the actual decision-making. In one country, for example, support was successfully obtained for the practice of supplying essential (rather than expensive but less relevant) drugs at local level, when local associations of general practitioners confronted town councils and other civic bodies with the alternatives. A second means of dispelling misconceptions could be the mass media. The Technical Discussions concluded that WHO, the Council for International Organizations of Medical Sciences, the International Union for Health Education, and other bodies should carefully select and develop simple and clear, yet comprehensive, messages for the purpose and test them from the standpoints of transmission, reception, and impact.

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Group 1:	Chairman:	Dr H. Hellberg, Finland
	Rapporteur:	Dr D. Krebs, International Council of Nurses
	Secretary:	Dr G. Rifka/Dr C. Karamustakia, WHO Regional Office for the Eastern Mediterranean
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Group 2:	Chairman:	Dr D. Sebina, Botswana
	Rapporteur:	Dr Khin Maung Kywe, Burma
	Secretary:	Dr H. Vuori, WHO Regional Office for Europe
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